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DR. LUSBY  
 2308 N. POTOMAC ST  
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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10746

## CERTIFICATE OF DEATH

10656

<b>1. PLACE OF DEATH</b> a. COUNTY <u>WASHINGTON</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN 1b <u>3 WEEKS</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON COUNTY HOSPITAL</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MT. LENA - RURAL</u> d. STREET ADDRESS <u>BOONSBORO MD. R. 2.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>BESSIE ALBERTA ARNOLD</u>			<b>4. DATE OF DEATH</b> Month Day Year <u>SEPTEMBER 26 1960</u>				
<b>5. SEX</b> <u>FEMALE</u>	<b>6. COLOR OR RACE</b> <u>WHITE</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>APRIL 27 - 1883</u>	<b>9. AGE</b> (In years lost birthday) <u>77</u> yrs. IF UNDER 1 YEAR: Months <u>4</u> Days <u>29</u> Hours <u> </u> Min. <u> </u>	<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>OWN HOME</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>MARTINSBURG W. VA.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>DAVID STINE</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>CLARA BAKER</u>				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>		<b>17. INFORMANT</b> Address <u>MRS. PEARL SWOPE BOONSBORO MD. R. 2.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Heart Disease with Fibrillation</u> <u>420.0</u> DUE TO <u>+ myocardial failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute Gangrenous appendicitis - appendectomy - two weeks ago</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u> </u>							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>60</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u> </u> <b>20f. (City or town)</b> (County) (State) <u> </u>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>9 Sept 1960</u> <b>to</b> <u>26 Sept 60</u> <b>that (I) (we) last saw the deceased alive and</b> <u>26 Sept 1960</u> <b>and that death occurred at</b> <u>2:30 P.M.</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>F. F. Lusby</u>		<b>22b. DATE SIGNED</b> <u>27 Sept 60</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>F. F. Lusby</u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>SEPT. 30, 1960</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>MT. LENA CEMETERY</u>			
<b>23d. LOCATION (City, town, or county)</b> (State) <u>MT. LENA WASH. CO. MD</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <u>John D. Baer BOONSBORO MD.</u>					
<b>25a. REC'D BY REGISTRAR</b> DATE <u>OCT 3 '60</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles S. Kenna</u>					

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OFFICE OF THE  
DIRECTOR OF THE  
BUREAU OF THE  
CENSUS

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THE BUREAU OF THE CENSUS  
HAS THE HONOR TO ACKNOWLEDGE  
THE RECEIPT OF YOUR LETTER  
OF THE 10TH INSTANT  
IN WHICH YOU REQUESTED  
A COPY OF THE  
REPORT OF THE  
COMMISSIONER OF THE  
BUREAU OF THE CENSUS  
FOR THE YEAR 1900  
AND TO INFORM YOU THAT  
A COPY OF THE SAME  
IS BEING FORWARDED  
TO YOU BY MAIL  
THIS DAY.

Very respectfully,  
J. Edgar Hoover,  
Director.

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10804

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10657

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Conococheague</b>				c. LENGTH OF STAY IN 1b <b>8 wks</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Gateway Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>David</b> Middle <b>Floyd</b> Last <b>Bittle</b>				4. DATE OF DEATH Month <b>9</b> Day <b>24</b> Year <b>1960</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/27/1870</b>		9. AGE (In years lost birthday) <b>90</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farm owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>William Metzger Bittle</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Routzahn</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. Simon Summers, Middletown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> <b>general arteriosclerosis with</b> DUE TO <b>asthenosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>asthenosclerotic heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bilateral indirect inguinal hernia - partial strangulation</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 7</b> 19 <b>60</b> , to <b>Sept 24</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>Sept 23</b> 19 <b>60</b> , and that death occurred at <b>4:50</b> P. M. from the causes and on the date stated above.							
22a. SIGNATURE <b>Edward W. Ditt III</b>				22b. DATE SIGNED <b>9/25/60</b>		22c. PHYSICIAN'S NAME (Type) <b>Edward W. Ditt III, MD</b>	
22d. ADDRESS <b>217 W. Washington St Hagers town, Md</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>9/27/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Myersville, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Gladhill Company, Middletown, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>SEP 28 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10747 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10731

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>524 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Western Md. State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>Bledsoe</u> Last <u></u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>21</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-10-09</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William R. Hendershott</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Hulsutta</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>✓</u>		16. SOCIAL SECURITY NO. <u>2</u>	
17. INFORMANT <u>University Hospital Records</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>aspiration of vomitus</u> 962X DUE TO <u>Cerebral Contusion + lacerations</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Subarachnoid + Chr. Hypertension</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>Recent</u> <u>17 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <u>Fell down stairs</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year <u>3-3-1959</u> Hour <u>1</u> a.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Baltimore</u> (County) <u>Md.</u> (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>J. E. W. Smith</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>J. E. W. Smith</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/23/1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suter - Rouzer Funeral Home</u>		24a. REC'D BY REGISTRAR <u>SEP 23 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>C. E. Hume</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10742

NAME OF DECEASED [Faint text]		SEX [Faint text]	
AGE [Faint text]		DATE OF BIRTH [Faint text]	
PLACE OF BIRTH [Faint text]		OCCUPATION [Faint text]	
MARITAL STATUS [Faint text]		CAUSE OF DEATH [Faint text]	
MANNER OF DEATH [Faint text]		MEDICAL HISTORY [Faint text]	
PRESENT ILLNESS [Faint text]		TREATMENT [Faint text]	
PHYSICIAN'S SIGNATURE [Faint text]		MEDICAL EXAMINER'S SIGNATURE [Faint text]	
DATE OF EXAMINATION [Faint text]		PLACE OF EXAMINATION [Faint text]	
SIGNATURE OF MEDICAL EXAMINER [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]	
DATE OF SIGNATURE [Faint text]		PLACE OF SIGNATURE [Faint text]	

OFFICE OF THE MEDICAL EXAMINER  
 BALTIMORE, MARYLAND

TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

10732

10748

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>10 years 03</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rebecca</u> Middle <u>M.</u> Last <u>Blickenstaff</u>				4. DATE OF DEATH Month <u>9</u> Day <u>25</u> Year <u>19 60</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/8/1882</u>		9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Michael Kline</u>				14. MOTHER'S MAIDEN NAME <u>Mary Maugans</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. George Bussard, Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>24 days</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. 11</u> Month <u>19</u> Day <u>19</u> Year <u>1960</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January</u> , 19 <u>60</u> , to <u>Sept 24</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Sept 24</u> , 19 <u>60</u> , and that death occurred at <u>3:00 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John D. Turco</u>				ADDRESS (Street, city or town, state) <u>302 W. POTOMAC ST</u>		DATE SIGNED <u>9/26/60</u>	
PHYSICIAN'S NAME (Type) <u>Dr. John Turco</u>				<u>HAGERSTOWN, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>9/28/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Luthan Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Wolfsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Company, Middletown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 28 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10733

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Tilghmanton rural</b>		c. LENGTH OF STAY IN 1b <b>18 weeks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Nannie</b> Middle <b>May</b> Last <b>Bloyer</b>		4. DATE OF DEATH Month <b>9</b> Day <b>11</b> Year <b>19 60</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-23-1882</b>
9. AGE (In years lost birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	
11. BIRTHPLACE (State or foreign country) <b>Clearspring, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Adam Repp</b>		14. MOTHER'S MAIDEN NAME <b>Rose Ann Myers</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-36-0765</b>	
17. INFORMANT <b>Mrs. Russell Carbaugh</b>		Address <b>Boonsboro, Md. RI</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>581.0</b> DUE TO <b>Carbolic Poison</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Gum abscess</b> (c) <b>abscess</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>5 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 1, 1960</b> , to <b>Sept 11, 1960</b> , that (I) (we) last saw the deceased alive on <b>9-10-60</b> , and that death occurred at <b>9 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>A. E. W. Kraiss</b>		22b. DATE SIGNED <b>9/12/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. E. W. Kraiss</b>		22d. ADDRESS <b>Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>9-14-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Pauls</b>		23d. LOCATION (City, town, or county) (State) <b>Clearspring Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b>		ADDRESS <b>Hagerstown, Md.</b>	
25a. REC'D BY REGISTRAR DATE <b>SEP 15 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Krauss</b>	

110831

CERTIFICATE OF DEATH

102405

WILLIAMSON, VIRAL 12 weeks 11/11/1962

Female, white, 5' 7" 110 lbs. 11/11/1962

Home, 1101 S. 11th St., Phoenix, Ariz.

Home, 1101 S. 11th St., Phoenix, Ariz.

Home, 1101 S. 11th St., Phoenix, Ariz.

Home, 1101 S. 11th St., Phoenix, Ariz.

Home, 1101 S. 11th St., Phoenix, Ariz.



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10749

CERTIFICATE OF DEATH

302

10734

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>3 Days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown R # 1</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash County Hospital</b>		d. STREET ADDRESS <b>1 Mt Aetna</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MELVIN CHARLES BOHN</b>		4. DATE OF DEATH <b>September 20 1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 22 1899</b>	9. AGE (In years last birthday) <b>61</b> yrs.	IF UNDER 1 YEAR <b>Months Days Hours Min.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner-Operator Auto</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Salvage</b>		11. BIRTHPLACE (State or foreign country) <b>Md. near Union Bridge Carroll Co</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Charles J. Bohn</b>		14. MOTHER'S MAIDEN NAME <b>Ursula Grossnickle</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-10-6812</b>		17. INFORMANT <b>Mrs Nina B. Bohn Hagerstown R # 1</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO <b>181.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Carcinoma of Urinary Bladder.</b> (b) <b>5 years.</b> (c) <b>5 years.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 months.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/13/56</b> 19____, to <b>9/20/60</b> 19____, that (I) (we) last saw the deceased alive on <b>9/20/60</b> 19____, and that death occurred at <b>4:30PM</b> from the causes and on the date stated above.		22a. SIGNATURE <b>J. G. Warden</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>J. G. Warden, M. D.</b>		22d. ADDRESS <b>832 Potomac Ave., Hagerstown, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/23/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Beaver Dam Cemetery near Union Bridge Carroll Co Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		25a. REC'D BY REGISTRAR <b>SEP 26 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>	

11234

503

CERTIFICATE OF DEATH

10740

M

MADE PUBLIC BY THE HEALTH DEPARTMENT  
OF THE DISTRICT OF COLUMBIA  
ON THE 10TH DAY OF JULY 1961  
AT WASHINGTON, D.C.  
I, the undersigned, being a duly qualified medical officer of health for the District of Columbia, do hereby certify that  
the within and foregoing is a true and correct copy of the original as the same appears from the records of the Department of Health.  
WITNESSED my hand and the seal of the Department of Health this 10th day of July 1961.  
JOHN W. HARRIS, M.D., M.P.H.  
Medical Officer of Health  
District of Columbia  
The seal of the Department of Health is hereunto affixed.  
JOHN W. HARRIS, M.D., M.P.H.  
Medical Officer of Health  
District of Columbia  
The seal of the Department of Health is hereunto affixed.  
JOHN W. HARRIS, M.D., M.P.H.  
Medical Officer of Health  
District of Columbia  
The seal of the Department of Health is hereunto affixed.

1

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

10750

10735

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>15 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1415 Sherman Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Melvin</b> Middle <b>Abraham</b> Last <b>Butts, Jr.</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>24</b> , Year <b>1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 20, 1945</b>
9. AGE (In years last birthday) yrs. <b>15</b>		10. IF UNDER 1 YEAR Months <b>15</b> Days <b>15</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Melvin A. Butts, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Betty Semler</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Melvin A. Butts, Sr., Hagerstown, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>glaucoma &amp; tumor of brain stem</b> DUE TO <b>193.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <b>4 Mos</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 22, 1960</b> , to <b>Sept 24, 1960</b> , that (I) (we) last saw the deceased alive on <b>Sept 24, 1960</b> , and that death occurred at <b>3:45 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Edward W. Ditto III</b>		22b. DATE SIGNED <b>9/24/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edward W. Ditto III, M.D.</b>		22d. ADDRESS <b>217 West Washington Street Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>9-27-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. View Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Sharpsburg, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 26 '60</b>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

1975

CERTIFICATE OF DEATH

1975

(M)

Robertson 15 years

1115 Sherman Ave. 1115 Sherman Ave.

Male White 1915-1975 15

Barry Junior Melvin A. Brown, Jr.

Robertson, Ill. Robertson, Ill.

(1)

Barry Junior Melvin A. Brown, Jr.

Robertson, Ill. Robertson, Ill.

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 *Aug 9/29/60*  
10751 CERTIFICATE OF DEATH 10736  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Franklin</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY in 1b <u>3 hours 30 mins.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shady Grove</u> <u>75X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>P.O. Box 49</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Darell E. Carbaugh</u>				4. DATE OF DEATH Month Day Year <u>Sept. 29 1960</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/29/60</u>		9. AGE (In years last birthday) yrs. Months Days Hours Min. <u>3 30</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Orrin Lee Carbaugh</u>				14. MOTHER'S MAIDEN NAME <u>Faye Marie Helman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Orrin Lee Carbaugh, Shady Grove Pa. Box 49</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>761.5</u> DUE TO <u>PREMATURITY</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PRE-MATURE SEPARATION OF PLACENTA</u> 24 hrs (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>29 Sept., 1960</u> , to <u>29 Sept., 1960</u> , that I last saw the deceased alive on <u>29 Sept., 1960</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.				PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/4/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Waynesboro Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>[Signature]</u> <u>Waynesboro, Pa.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 5 1960</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Trans</u>	

2081191XV0

CERTIFICATE OF DEATH

1974

NAME OF DECEASED [Blank]		SEX [Blank]		AGE [Blank]	
RACE [Blank]		BIRTH DATE [Blank]		BIRTH PLACE [Blank]	
MARRIAGE [Blank]		OCCUPATION [Blank]		CAUSE OF DEATH [Blank]	
PLACE OF DEATH [Blank]		TIME OF DEATH [Blank]		DATE OF DEATH [Blank]	
SIGNATURE OF DECEASED [Blank]		SIGNATURE OF WITNESS [Blank]		SIGNATURE OF PHYSICIAN [Blank]	
SIGNATURE OF CLERK [Blank]		SIGNATURE OF REGISTRAR [Blank]		SIGNATURE OF JUDGE [Blank]	
SIGNATURE OF SHERIFF [Blank]		SIGNATURE OF CORONER [Blank]		SIGNATURE OF JURY [Blank]	
SIGNATURE OF DISTRICT ATTORNEY [Blank]		SIGNATURE OF COUNTY CLERK [Blank]		SIGNATURE OF CITY CLERK [Blank]	
SIGNATURE OF MAYOR [Blank]		SIGNATURE OF COMMISSIONER [Blank]		SIGNATURE OF HEALTH COMMISSIONER [Blank]	
SIGNATURE OF DEPARTMENT OF HEALTH [Blank]		SIGNATURE OF BALTIMORE CITY [Blank]		SIGNATURE OF MARYLAND [Blank]	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

10737

10752

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>5 weeks</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Granton</b> Middle <b>Charlton</b> Last <b>Charlton</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>19</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 12 1900</b>	
9. AGE (In years last birthday) <b>60</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumber</b>		11. BIRTHPLACE (State or foreign country) <b>Harrisburg Va</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Casper Charlton</b>				14. MOTHER'S MAIDEN NAME <b>Mattie Keplinger</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>				16. SOCIAL SECURITY NO. <b>217 10 2889</b>			
17. INFORMANT <b>Mrs. May Charlton</b>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS, GENERALIZED</b> DUE TO <b>CARCINOMA OF THE LUNG</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>NONE</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <b>8 MONTHS</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>FEB 16</b> 19 <b>60</b> to <b>SEPT. 19</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>SEPT. 19</b> 19 <b>60</b> , and that death occurred at <b>7.25 AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <i>Archie Robert Cohen</i>				22b. DATE SIGNED <b>SEPT. 20, 1960</b>			
22c. PHYSICIAN'S NAME (Type) <b>ARCHIE ROBERT COHEN, M.D.</b>				22d. ADDRESS <b>CLEAR SPRING, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept. 21-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rosehill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Albert L. Leaf</i>				25a. REC'D BY REGISTRAR DATE <b>SEP 21 '60</b>		25b. REGISTRAR'S SIGNATURE <i>Charles S. Frawley</i>	

(M)

(I)

DELYAN, G. and G. N. NALDO

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10739

10753

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>most of life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Western Maryland State Hospital</b>				d. STREET ADDRESS <b>144 Madison Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Harvey</b> Middle <b>Clinton</b> Last <b>CLINE</b>				4. DATE OF DEATH Month <b>9</b> Day <b>3</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 29, 1884</b>	
9. AGE (In years, lost birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months <b>76</b> Days <b>76</b> Hours <b>76</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Night Watchman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Restraunt</b>	
11. BIRTHPLACE (State or foreign country) <b>Battletown, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Samuel Cline</b>		14. MOTHER'S MAIDEN NAME <b>Laura Bavey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. Emma Cline</b>		Address <b>Hagerstown, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary atherosclerosis</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>10 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture of femur</b> <b>Lobular pneumonia</b> <b>generalized arteriosclerosis</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>Injury sustained following fall.</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter signature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>July 7 19 60</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>				20f. (City or town) (County) (State) <b>Hagerstown Wash. Md.</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 11, 1960</b> to <b>Sept. 3, 1960</b> that (I) (we) last saw the deceased alive on <b>Sept. 3, 1960</b> and that death occurred at <b>7:30 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Young E. Chun</b>				22b. DATE SIGNED <b>Sept. 3, 1960</b>			
22c. PHYSICIAN'S NAME (Type) <b>Young E. Chun</b>				22d. ADDRESS <b>1500 Penna. Ave. Hagerstown, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/6/1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Church Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Leitersburg, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. Fran Alvin Rouzer</b>				25a. REC'D BY REGISTRAR <b>SEP 6 '60</b>			
ADDRESS <b>Hagerstown, Md.</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kinn</b>			

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DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10740

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write ROUTE 2, CLEAR SPRING, MD.)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROUTE 2, CLEAR SPRING, MD.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RESIDENCE</b>				d. STREET ADDRESS <b>ROUTE 2, CLEAR SPRING, MD.</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>GEORGE DAVID CLOPPER</b>				4. DATE OF DEATH Month Day Year <b>SEPT. 17 1960</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 6, 1885</b>		9. AGE (In years lost birthday) <b>74 yrs.</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SELF EMPLOYED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CARPENTER</b>		11. BIRTHPLACE (State or foreign country) <b>BLAIRS VALLEY, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN HENRY CLOPPER</b>				14. MOTHER'S MAIDEN NAME <b>MARTHA ELLEN BARNHART</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>MRS LOTY V. CLOPPER</b>		Address <b>ROUTE 2, CLEAR SPRING, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.0</b> IMMEDIATE CAUSE (a) <b>Coronary artery occlusion with myocardial infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>one hour</b>  <b>one year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Possible Gastric Malignancy</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 25, 1960</b> to <b>September 17, 1960</b> , that (I) (we) last saw the deceased alive on <b>Sept. 17, 1960</b> , and that death occurred at <b>3:10 AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <i>Archie Robert Cohen</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE <b>Sept. 18, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Archie Robert Cohen, M.D.</b>				22d. ADDRESS <b>Clear Spring, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>Sept. 19, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BLAIRS VALLEY CE.</b>		23d. LOCATION (City, town, or county) (State) <b>BLAIRS VALLEY, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John F. Clark</i>				ADDRESS <b>CLEAR SPRING, MD.</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 21 '60</b>	
				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>			

CERTIFICATE OF DEATH

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

10741

10754

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>14 months</b> d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Washington County Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b> d. STREET ADDRESS <b>1500 Northern Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Lorene Lillian Colyer</b>				4. DATE OF DEATH <b>September 16 1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 10, 1929</b>	
9. AGE (In years last birthday) <b>31</b> yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>16</b> Hours <b>0</b> Min. <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>St. Louis Mo.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>Mo.</b>							
13. FATHER'S NAME <b>John Buller</b>				14. MOTHER'S MAIDEN NAME <b>Irene Viehman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>491-26-0218</b>		17. INFORMANT <b>Robert Colyer Hagerstown Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO (b) <b>Ca of endometrium with metastases (generalized)</b> DUE TO (c) <b>metastases (generalized)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>No</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 16 1959</b> to <b>16 Sept 1960</b> that (I) (we) last saw the deceased alive on <b>16 Sept 1960</b> , and that death occurred at <b>1:30</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Harold H. Gist</b>				22b. DATE SIGNED <b>9-17-60</b>			
22c. PHYSICIAN'S NAME (Type) <b>Harold H. Gist</b>				22d. ADDRESS <b>N. Potomac St Hagerstown Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9-18-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St Pauls Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Creve Coer Mo.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>				ADDRESS <b>Hagerstown Md.</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 19 60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. [unclear]</b>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

Reg. Dist. No.

10799

10755

1. PLACE OF DEATH a. COUNTY <u>Washington County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>--</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Shirley Ann Witmer COOPER</u>				4. DATE OF DEATH Month Day Year <u>Sept. 7 19 60</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 7, 1960</u>	9. AGE (In years lost birthday) yrs. <u>20</u>	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James Clifton Cooper</u>				14. MOTHER'S MAIDEN NAME <u>Elsie Viola Witmer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Apnea due to delay in delivering after coming head (Breech presentation).</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 7</u> , 19 <u>60</u> , to <u>Sept. 7</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Sept. 7</u> , 19 <u>60</u> , and that death occurred at <u>12 noon</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Dr. F.F. Lusby, 230 N. Pot. St., Hag., Md.</u> ACTUAL SIGNATURE <u>F.F. Lusby</u> M.D. PHYSICIAN'S NAME (Type) <u>F.F. Lusby</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>9/10/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Co. Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F.F. Lusby M.D.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 14 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10756

10742

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>2 1/2</b> hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Lewis Llewellyn Cross</b>		4. DATE OF DEATH <b>September 20 19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 22, 1894</b>
9. AGE (In years lost birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Yard Master</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>St. James Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Lewis Cross</b>		14. MOTHER'S MAIDEN NAME <b>Llewella Clagett</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>705-10-5285</b>	
17. INFORMANT <b>Mrs. Mary K. Cross</b>		Address <b>Hagerstown Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> DUE TO (b) <b>4-20-60</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>13 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 1954</b> , to <b>9-20</b> , 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>8-20</b> , 19 <b>60</b> , and that death occurred at <b>8:20 P.M.</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Dalton M. Welty</b>		22b. DATE SIGNED <b>9-21-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dalton M. Welty, M.D.</b>		22d. ADDRESS <b>998 Potomac Ave., Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9-23-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>		25a. REC'D BY REGISTRAR <b>SEP 26 '60</b>	
ADDRESS <b>Hagerstown Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	





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 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

10743

10757

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>PENNSYLVANIA</b> b. COUNTY <b>FRANKLIN</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>9 MO.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MARTIN MANOR REST HOME</b>				d. STREET ADDRESS <b>60 W. MADISON ST.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARY LUSETTA DALEY</b>				4. DATE OF DEATH Month Day Year <b>SEPTEMBER 22 19 60</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/19/1887</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>CHARLES SCHENEBECK</b>				14. MOTHER'S MAIDEN NAME <b>ANNIE BARNES</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>NONE</b>		17. INFORMANT <b>GREENCASTLE PENNA.</b> <b>GEORGE SHATZER</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> DUE TO <b>C.V.D.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Anterior</b> DUE TO <b>leukemia</b> (c) <b>Hypertension</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>any</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH <b>331X</b> <b>go</b> <b>2</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>— 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>any</b> 19 <b>56</b> to <b>9/22</b> 19 <b>60</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>9/22</b> 19 <b>60</b> , and that death occurred at <b>—</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Louis G. Graff, M.D.</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Louis G. Graff, M.D.</b>				22d. ADDRESS <b>119 E. Antietam St., Hagerstown, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>9/25/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PLEASANT HILL U.B. CHURCH</b>		23d. LOCATION (City, town, or county) (State) <b>COSEYTOWN PENNA.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>A. E. Minnich</b>				ADDRESS <b>Greencastle Pa.</b>		25a. REC'D BY REGISTRAR <b>SEP 26 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

9. V. 3

mountain!

15/0

*H. E. Mendenhall*

1  
Page 4  
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10758

CERTIFICATE OF DEATH

10744

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>1 yr.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Piper Lane</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <b>Piper Lane</b>	
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>Almeda</b> Last <b>Davis</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>15</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 15 1882</b>
9. AGE (In years lost birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months <b>11</b> Days <b>0</b>	
IF UNDER 24 HRS. Hours <b></b> Min. <b></b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Tannery</b>		11. BIRTHPLACE (State or foreign country) <b>Williamsport Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Cornelius Davis</b>	
14. MOTHER'S MAIDEN NAME <b>Catherine Davis</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>215 019847</b>		17. INFORMANT <b>Mrs. Clyde Fleagle</b> Address <b>Piper Lane Hagerstown Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Copiously Thrown Back</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>Substate</b> (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>Substate</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>7/16/60</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>7/16/60</b>		20f. (City or town) (County) (State) <b>Hagerstown</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>7/16/60</b> to <b>9/16/60</b> , that (I) (we) last saw the deceased alive on <b>7/16/60</b> , and that death occurred at <b>7</b> M., from the causes and on the date stated above.			
22a. SIGNATURE <b>Edith V. Leaf</b>		22b. DATE SIGNED <b>9/16/60</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>Williamsport</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept. 17-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Williamsport Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Edith V. Leaf</b>		25a. REC'D BY REGISTRAR <b>SEP 19 '60</b>	
ADDRESS <b>Williamsport</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10807 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 10745

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>PA.</b> b. COUNTY <b>BEAVER</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BIG SPRING, MD.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ALIQUIPPE 308 FRANKLIN AVE.,</b>	
c. LENGTH OF STAY IN 1b <b>5 DAYS</b>		d. STREET ADDRESS <b>ALIQUIPPE, PA. 75X3</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ROUTE 1 BIG SPRING, MD.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM LLOYD DAVIS</b>		4. DATE OF DEATH Month <b>SEPT.</b> Day <b>5</b> Year <b>19 60</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 2, 1900</b>
9. AGE (In years last birthday) <b>60 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WATER TENDER</b>	
11. BIRTHPLACE (State or foreign country) <b>WASHINGTON CO. MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FRANK DAVIS</b>		14. MOTHER'S MAIDEN NAME <b>CATHERINE MYERS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>162-16-3029</b>	
17. INFORMANT <b>MRS WILLIAM L. DAVIS, ALIQUIPPE, PA.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUODENAL ULCER</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>3 HRS.</b> RECENT			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>DR. E. W. DITTO JR.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>DR. E. W. DITTO JR.</b>		DATE SIGNED <b>9/6/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>SEPT. 8, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>PENNSYLVANIA MEMORIAL PARK</b>		22d. LOCATION (City, town, or county) (State) <b>ROCHESTER PA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank A. Konstantin Jr.</b>		24a. REC'D BY REGISTRAR <b>SEP 7 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
1925  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED JAMES M. JONES		AGE 35		SEX Male		RACE White	
DATE OF DEATH April 15, 1925		PLACE OF DEATH Home		CITY Baltimore		COUNTY Baltimore	
CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural		DISEASE OR INJURY Coronary Artery Disease		LOCALITY OF BIRTH Maryland	
EDUCATION High School		OCCUPATION Salesman		MARITAL STATUS Married		RELIGION Roman Catholic	
PREVIOUS ILLNESS None		TREATMENT None		HISTORY OF DRUGS None		HISTORY OF ALCOHOL None	
SIGNATURE OF EXAMINER J. M. Jones		DATE April 15, 1925		PLACE Baltimore		COUNTY Baltimore	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

10759

CERTIFICATE OF DEATH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10746

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>1 month</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sharpsburg</b> d. STREET ADDRESS <b>311 W. Main Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lucy</b> Middle <b>Caroline</b> Last <b>Ditto</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>10</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 22 1888</b>
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months <b>5</b> Days <b>18</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Public School</b>	11. BIRTHPLACE (State or foreign country) <b>Sharpsburg Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13. FATHER'S NAME <b>Edward Lee Grayson</b>	
14. MOTHER'S MAIDEN NAME <b>Selma Morland</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>212 38 7662</b>		17. INFORMANT <b>John Grayson</b> Address <b>311 W. Main Street Sharpsburg Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b> DUE TO <b>153.3</b> Left Femoral Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Generalized Abdominal Carcinomatosis</b> SCIRRHUS CARCINOMA OF Sigmoid Colon PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b> <b>2 mos.</b> <b>2 mos</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 12, 1960</b> to <b>Sept 10, 1960</b> , that (I) <del>lost</del> saw the deceased alive on <b>Sept 10, 1960</b> , and that death occurred at <b>9:45 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>John A. Moran M.D.</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>JOHN A. MORAN M.D.</b>		22d. ADDRESS <b>215 W. WASHINGTON ST. HAG, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept. 13-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mumma Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Near Sharpsburg Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Albert Leaf Willemore, Md</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 13 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>			



1  
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

10760

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH 302

10747

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN lb <b>5 Days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash County Hospital</b>		d. STREET ADDRESS <b>1 248 No Mulberry St</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>JESSE</b> First <b>RAYMOND</b> Middle <b>EICHELBERGER</b> Last		4. DATE OF DEATH <b>Sept 11 1960</b> Month <b>11</b> Day <b>19</b> Year				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 5 1888</b>	9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman Md Ribbon Co</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Millstone Wash co Md</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>John Eichelberger</b>		14. MOTHER'S MAIDEN NAME <b>Katherine McAllister</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>----- 314-09-6780</b>		17. INFORMANT Address <b>Harold E. Eichelberger</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho pneumonia</b> DUE TO <b>293x</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>Aplastic anemia</b> DUE TO (c)		248 No Mulberry St Hagerstown Md.		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>15 m. 24 h</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>7 Sept 1960</b> to <b>11 Sept 1960</b> , that (I) (we) last saw the deceased alive on <b>11 Sept 1960</b> , and that death occurred at <b>11 Sept</b> M, from the causes and on the date stated above.						
22a. SIGNATURE <b>Edmon D. Hoachlander</b> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>9/12/60</b>		
22c. PHYSICIAN'S NAME (Type) <b>Edmon D. Hoachlander</b>		22d. ADDRESS <b>Hagerstown Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>9/14/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash Co Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		ADDRESS <b>Hagerstown Md.</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 15 '60</b>		25b. REGISTRAR'S SIGNATURE <b>William S. Kraus</b>

10710

CERTIFICATE OF DEATH

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MAINTENANCE OF RECORDS  
DEPARTMENT OF JUSTICE  
CENTRAL FILE OF DEATH

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1080s

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10749

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>Maryland</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Weaverton</u>		c. LENGTH OF STAY IN 1b <u>Unknown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>811 George Street Baltimore Maryland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>811 George Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Donald</u> First <u>Samuel</u> Middle <u>Fletcher</u> Last				4. DATE OF DEATH <u>September-5th.-</u> 1960 Month Day Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March-12-1898</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer In General</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>In General</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A. Yes</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>No</u>		17. INFORMANT <u>Susie Fletcher 811 George Street</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>822X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>FRACTURED SKULL, CRUSHED CHEST, CRUSHED LEFT SHOULDER, FRACTURED RIGHT ARM, LEFT CLAVICLE</u> DUE TO (c) <u>INSTANT</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Truck overturned</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>11:30</u> <u>9-5</u> 19 <u>60</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>RT 340 WEAVERTON</u>		20f. (City or town) (County) (State) <u>WEAVERTON WASH CO MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>DR E W DITTO, JR</u> EXAMINER'S NAME (Type)				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/10/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Brooklyn Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Eloy C. Wilson 1000 Brantley Avenue</u> ADDRESS				24a. REC'D BY REGISTRAR <u>SEP 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	



10799

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10750

Item 1, Film 271 9-26-60 et

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u>				c. LENGTH OF STAY IN 1b <u>6 MONTHS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>119 LAKIN AVE (Private Home)</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>HARRY BIGGS FRIEND</u>				4. DATE OF DEATH <u>SEPTEMBER-15, 1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL-25-1879</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		10. MONTHS <u>4</u> DAYS <u>20</u> HOURS <u></u> MIN. <u></u>		11. BIRTHPLACE (State or foreign country) <u>ST. JAMES WASH. CO MD. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>			
13. FATHER'S NAME <u>JACOB FRIEND</u>				14. MOTHER'S MAIDEN NAME <u>ALICE HILL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>HUGH A. FORD</u> Address <u>BOONSBORO MD.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized atherosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute hemorrhage from peptic ulcer</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs</u> <u>5 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>May 2, 1960</u> to <u>Sept. 15, 1960</u> , that (I) (we) last saw the deceased alive on <u>Sept. 14, 1960</u> , and that death occurred at <u>St. M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>G. W. Lellan</u>				22b. DATE SIGNED <u>9/16/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>G. W. Lellan</u>				22d. ADDRESS <u>Boonsboro Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>SEPT-18-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MOUNTAIN VIEW CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>SHARPSBURG MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Bast</u>				25. REC'D BY REGISTRAR <u>Boonsboro MD.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles E. Kneass</u>	

MEDICAL CERTIFICATION

10730

CERTIFICATE OF DEATH

10730

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Blank lines for text entry.

TO HOSPITAL - ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND																													
10800 CERTIFICATE OF DEATH																													
10751																													
1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>																								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BOONSBORO</b>					c. LENGTH OF STAY IN 1b <b>10 MO.</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 HAGERSTOWN</b>																			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>REEDER NURSING HOME</b>					d. STREET ADDRESS <b>1621 VIRGINIA AVE.</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>JEFFERSON</b> Last <b>FUNKHOUSER</b>					4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>27</b> Year <b>19 60</b>																								
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/22/1882</b>		9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.																	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED GUARD</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>AIRCRAFT CO.</b>					11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>					12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>														
13. FATHER'S NAME <b>GODFREY FUNKHOUSER</b>					14. MOTHER'S MAIDEN NAME <b>MARY JANE STEELE</b>					15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>					16. SOCIAL SECURITY NO. <b>212-14-6488</b>					17. INFORMANT <b>MR. LUTHER FUNKHOUSER</b>					Address <b>CLEARSPRING MD.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized arteriosclerosis</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Malnutrition</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>6 yrs 6 mon.</b>										PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>March 10, 1960</b> to <b>Sept 27, 1960</b> , that (I) (we) last saw the deceased alive on <b>Sept 26, 1960</b> , and that death occurred at <b>2 PM</b> , from the causes and on the date stated above.															22a. SIGNATURE <b>G. W. Wilson</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED <b>9/28/60</b>				
22c. PHYSICIAN'S NAME (Type) <b>G. W. Wilson</b>					22d. ADDRESS <b>Boonsboro</b>					22e. ADDRESS <b>Ind.</b>																			
23a. BURIAL, CREMATION, REINTERMENT (Specify) <b>BURIAL</b>					23b. DATE THEREOF <b>9/29/60</b>					23c. NAME OF CEMETERY OR CREMATORY <b>REST HAVEN CEM.</b>					23d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>														
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Horvath, Hagerstown, Md.</b>										ADDRESS					25a. REC'D BY REGISTRAR DATE <b>SEP 30 '60</b>					25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>									

10701

UNITED STATES DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
FEDERAL BUREAU OF INVESTIGATION  
CERTIFICATE OF DEATH

10701

(M)

NAME OF DECEASED WASHER, JR.		AGE 30 Y.	SEX M
DATE OF DEATH JAN 17 1948		PLACE OF DEATH JACKSON, MISSISSIPPI	CAUSE OF DEATH HEART DISEASE
MANNER OF DEATH NATURAL		DATE OF BIRTH JAN 17 1918	PLACE OF BIRTH JACKSON, MISSISSIPPI
OCCUPATION FARMER		EDUCATION HIGH SCHOOL	RELIGION METHODIST
MARRY, STATE, COUNTY MISSISSIPPI, JACKSON		DATE OF MARRIAGE JAN 17 1948	

215-14-1958

*[Faint, illegible handwritten notes and signatures]*

W. J. Harrison, Registrar



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>most of Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				d. STREET ADDRESS <b>1423 S. Potomac Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>ERROL</b> Last <b>GEARY</b>				4. DATE OF DEATH Month <b>September</b> Day <b>19</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 11, 1899</b>	
9. AGE (In years lost birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sheet Metal Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Aircraft Company</b>		11. BIRTHPLACE (State or foreign country) <b>Clearspring, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Geary</b>				14. MOTHER'S MAIDEN NAME <b>Mary Jane Secrist</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-0900715</b>		17. INFORMANT <b>Mrs. Lorraine Geary Hagerstown, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis with r, hemiplegia</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis</b> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <b>6 days -</b> <b>unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6-18 1939</b> to <b>9-19 1960</b> that (I) (we) last saw the deceased alive on <b>9-19 1960</b> , and that death occurred <b>9:10 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>John H. Hornbaker</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>9:20:60</b>	
22c. PHYSICIAN'S NAME (Type) <b>John H. Hornbaker, M.D.</b>				22d. ADDRESS <b>154 West Washington St., Hagerstown, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/21/1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. Franklin Berger</b>				ADDRESS <b>Hagerstown, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 23 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

10752

CERTIFICATE OF DEATH

10752

no. 10752

date of death

cause of death

place of death

age at death

sex

marital status

signature of physician

signature of registrar

date of registration

place of registration

name of registrar

name of physician

name of informant

name of witness

name of witness

name of witness

name of witness

name of witness

name of witness

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

10753

10809

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>9 1/2 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RFD 2</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lessie</b> Middle <b>Leona</b> Last <b>Gerhart</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>9</b> Year <b>1960</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 15, 1885</b>
9. AGE (In years last birthday) <b>75 yrs.</b>		10. IF UNDER 1 YEAR Months <b>75</b> Days <b>75</b> Hours <b>75</b> Min. <b>75</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Big Pool, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>Big Pool, Md.</b>	
13. FATHER'S NAME <b>David L. Repp</b>		14. MOTHER'S MAIDEN NAME <b>Amanda Shadrach</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Gus R. Gerhart, Hagerstown, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.0</b> IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>Cardiovascular Heart Disease</b> <b>Exsanguination, Chronic</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>Exsanguination, Chronic</b> (c) <b>Exsanguination, Chronic</b> INTERVAL BETWEEN ONSET AND DEATH <b>30 minutes</b> <b>1 hr.</b> <b>1 hr.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 17, 1960</b> to <b>Sept 9, 1960</b> , that (I) (we) last saw the deceased alive on <b>Sept 6, 1960</b> , and that death occurred at <b>11 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Philip J. Hirshman</b>		22b. DATE SIGNED <b>9/10/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D.</b>		22d. ADDRESS <b>159 W. Washington St. Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9-12-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Shanktown Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>near Big Pool, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR <b>SEP 13 1960</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>		25c. DATE	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10763 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10754

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>ILLINOIS</u> b. COUNTY <u>LEE</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>4 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DIXON</u> <u>SIX-3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>316 GARLINGER AVENUE</u>				d. STREET ADDRESS <u>523 DEPOT STREET</u>			
3. NAME OF DECEASED (Type or print) First <u>LANA</u> Middle <u>GLOVER</u> Last				4. DATE OF DEATH Month <u>SEPTEMBER</u> Day <u>21</u> Year <u>1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 6, 1903</u>	9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months <u>9</u> Days <u>15</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MAPLEVILLE WASH. CO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HOWARD T. STOFFER</u>				14. MOTHER'S MAIDEN NAME <u>CARRIE GALOR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>MRS. L. R. BRITCHER</u> Address <u>316 GARLINGER ST HAGERSTOWN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Vascular Disease</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u> <u>Recent</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u></u> a. m. <u></u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>A. E. Ditto</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>9-22-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>SEPT. 24, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CHAPEL HILL CEMETERY</u>		22d. LOCATION (City, town, or county)		(State) <u>ILLINOIS</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. East</u>				24a. REC'D BY REGISTRAR <u>DATE OCT 3 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Hauer</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
10764  
CERTIFICATE OF DEATH

10755

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>4 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Oliver</b> Middle <b>Murphy</b> Last <b>Grove</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>28</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 20 1881</b>
9. AGE (In years lost birthday) yrs. <b>79</b>		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>7</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cemetery</b>	
11. BIRTHPLACE (State or foreign country) <b>Sharpsburg Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Otho Grove</b>		14. MOTHER'S MAIDEN NAME <b>Ella Swain</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>232-010429</b>	
17. INFORMANT <b>Mr. Clyde W. Grove</b>		Address <b>Sharpsburg Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gangrene of left leg</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Embolus of Left common iliac artery and</b> (c) <b>Multiple emboli to brain and lungs</b> (d) <b>Arteriosclerotic heart disease with auricular</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>fibrillation</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>4 days</b> <b>3 days</b> <b>5 Yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <del>Witnessed</del> attended the deceased from <b>9/20/60</b> 19 to <b>9/28/60</b> 19, that (I) (we) last saw the deceased alive on <b>9/27/60</b> 19, and that death occurred at <b>8A</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Walter H. Shealy</b>		22b. DATE SIGNED <b>Sep. 29, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Walter H. Shealy M. D.</b>		22d. ADDRESS <b>Sharpsburg, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept. 30-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. View Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Sharpsburg Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Almond Britton, Williamsport, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 3 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

1975

TEMPERATURE OF BRAIN

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1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
10810 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10756

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KEEDYSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KEEDYSVILLE</u>	
c. LENGTH OF STAY IN 1b <u>9 YEARS</u>		d. STREET ADDRESS <u>KEEDYSVILLE MD.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>KEEDYSVILLE MD.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FRANK ALLEN HAMMOND</u>		4. DATE OF DEATH <u>SEPTEMBER 15 1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCTOBER 30 1884 - 75 yrs.</u>
9. AGE (In years last birthday) <u>75</u>		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>15</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>	
11. BIRTHPLACE (State or foreign country) <u>SHARPSBURG WASH. CO. MD.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>NO RECORD</u>		14. MOTHER'S MAIDEN NAME <u>SUSAN HAMMOND</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215 36-6544</u>	
17. INFORMANT <u>ROYA HAMMOND</u>		Address <u>KEEDYSVILLE MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic Heart Disease</u> caused the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Died in roof and fell to the ground (7 ft)</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. <u>19</u> p. m.	
20c. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town) (County) (State)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>A. E. Smith</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOE W. H. T. 2</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>9/16/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEPT 18 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>KEEDYSVILLE WASH. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Kent</u>		24a. REC'D BY REGISTRAR <u>SEP 21 '60</u>	
ADDRESS <u>BOONSBORO MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 70  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10040

DATE OF DEATH

RESIDENT

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may be reviewed by the hospital or attending physician.

**DO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

## 10757

1984

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KEEDYSVILLE</b>		c. LENGTH OF STAY IN 1b <b>20 YEARS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KEEDYSVILLE</b>		d. STREET ADDRESS <b>1 KEEDYSVILLE MD</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>KEEDYSVILLE MD</b>		First <b>ROY</b>		Middle <b>ALLEN</b>		Last <b>HAMMOND</b>	
3. NAME OF DECEASED (Type or print) <b>ROY ALLEN HAMMOND</b>		4. DATE OF DEATH <b>SEPTEMBER-25-1960</b>		Month <b>SEPTEMBER</b>		Day <b>25</b>	
5. SEX <b>MALE</b>		6. COLOR OF RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 10 1908</b>	
9. AGE (In years last birthday) <b>52 yrs</b>		IF UNDER 1 YEAR Months <b>4</b>		Days <b>15</b>		IF UNDER 24 HRS. Hours <b>4</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GARAGE OPERATOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN GARAGE</b>		11. BIRTHPLACE (State or foreign country) <b>BAKERSVILLE WASH. Co. MD. U.S.A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>FRANK A. HAMMOND</b>		14. MOTHER'S MAIDEN NAME <b>VERVIE COCHRANE</b>		Address <b>KEEDYSVILLE MD</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220-05-6696</b>		17. INFORMANT <b>MRS. LELA HAMMOND</b>		Address <b>KEEDYSVILLE MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Coronary Thrombosis -</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) <b>DUE TO</b>		INTERVAL BETWEEN ONSET AND DEATH <b>420.1</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 15 1960</b> to <b>Sept 25 1960</b> , that (I) (we) last saw the deceased alive on <b>Sept 15 1960</b> , and that death occurred at <b>5 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>G. W. Helan</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS <b>Boonsboro</b>		22b. DATE SIGNED <b>9-27-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>G. W. Helan</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>SEPT-27-1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BOONSBORO CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>BOONSBORO WASH. Co. MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John H. East</b>		ADDRESS <b>BOONSBORO MD</b>		25a. REC'D BY REGISTRAR <b>DA TOCT 3 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kenna</b>	

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U.S. DEPARTMENT OF HEALTH  
AND HUMAN SERVICES  
BUREAU OF PUBLIC HEALTH  
WASHINGTON, D.C. 20492

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10765

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10758

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MATYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write <b>HAGERSTOWN</b> )		c. CITY OR TOWN (If outside corporate limits, write <b>HAGERSTOWN</b> )	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>		d. STREET ADDRESS <b>1232 E. FRANKLIN ST.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>GAIL</b> First <b>MARIE</b> Middle <b>HAYS</b> Last		4. DATE OF DEATH <b>SEPTEMBER 16 1960</b> Month Day Year	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>6/6/1898</b>
9. AGE (In years last birthday) <b>62</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN W. M. YEATES</b>		14. MOTHER'S MAIDEN NAME <b>ELIZA JANE CLOPPER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220-10-3385</b>	
17. INFORMANT <b>MR. ORVILLE C. HAYS</b>		Address <b>MDPT.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ADRENAL GLAND DEGENERATION</b> DUE TO <b>CARCINOMATOSIS GENERALIZED</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ADENOCARCINOMA OF THE BREAST, RIGHT</b> (c) <b>ADENOCARCINOMA OF THE BREAST, RIGHT</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 WEEK</b> <b>UNKNOWN</b> <b>5 YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>APRIL 30 1956</b> to <b>SEPT. 16 1960</b> , that (I) (we) last saw the deceased alive on <b>SEPT 15 1960</b> , and that death occurred at <b>10:25 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Archie Robert Cohen</b>		22b. DATE <b>09/18/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>ARCHIE ROBERT COHEN, M.D.</b>		22d. ADDRESS <b>CLEAR SPRING, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>9/18/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>SHANKS CHURCH OF BRETHERN</b>		23d. LOCATION (City, town, or county) (State) <b>FRANKLIN CO. PENNA.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Horne</b>		25a. REC'D BY REGISTRAR <b>SEP 20 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>			

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MEDICAL CERTIFICATION

10558

CERTIFICATE OF DEATH

10558



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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

10766

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH 302

10759

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>1 Yr</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>103 East Howard St</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>1103 East Howard St</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JACOB BURKETT HOSE</b>		4. DATE OF DEATH <b>September 4 1960 19</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 18 1881</b>
9. AGE (In years lost birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR: Months <b>03</b> Days <b>03</b> Hours <b>00</b> Min. <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mill wright</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Victor Products Willsons Wash Co Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John A. Hose</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Harsh</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-09-9141</b>	
17. INFORMANT <b>Mrs Hilda J. Baker</b>		Address <b>819 Maryland Ave Hagerstown Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Artery Sclerosis</b> DUE TO <b>Generalized Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>420.1</b> DUE TO (c) <b>Pyelonephritis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Pyelonephritis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>9/2 1960</b> Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9/2 1960</b> to <b>9/4 1960</b> , that (I) (we) last saw the deceased alive on <b>9/2 1960</b> , and that death occurred at <b>1030</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert V. H. Campbell</b>		22b. DATE SIGNED <b>9/6/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert V. H. Campbell</b>		22d. ADDRESS <b>145 W Washington ST Hagerstown Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/7/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash Co Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		25a. REC'D BY REGISTRAR <b>SEP 9 '60</b>	
ADDRESS <b>Hagerstown Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

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CERTIFICATE OF DEATH

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Generalized Convulsions

Hysteria

1911

Robert V. Campbell

Robert V. Campbell 145 W Washington St

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10760  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10760

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>17 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASH. CO. HOSPITAL</b>				d. STREET ADDRESS <b>420 N. MAIN ST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>F</b> Last <b>HUFFER</b>				4. DATE OF DEATH <b>SEPTEMBER - 9 - 1960</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 3, 1883</b>	
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>6</b>		IF UNDER 24 HRS. Hours <b>6</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MYERSVILLE FREE CO. MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>CARLTON P. RUTZAHN</b>				14. MOTHER'S MAIDEN NAME <b>CHARLOTTE E. YOUNG</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>ELMER C. HUFFER</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>576X</b> DUE TO <b>Acute peritonitis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>fracture of RT hip</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>fell on her kitchen floor</b>			
20c. TIME OF INJURY Month, Day, Year <b>8 22 1960</b> Hour <b>3</b> a.m. <b>3</b> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
20f. (City or town) <b>Boonsboro</b> (County) <b>WASH. MD</b> (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>8-22-1960</b> to <b>9-9-1960</b> , that (I) (we) last saw the deceased alive on <b>9-9-1960</b> , and that death occurred at <b>3:30 AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Joseph Secondari</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>9/10/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Joseph Secondari</b>				22d. ADDRESS <b>21 North Main St. Boonsboro, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>SEPT. 12, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BOONSBORO CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>BOONSBORO WASH. CO. MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Bast</b> ADDRESS <b>BOONSBORO MD.</b>				25a. REC'D BY REGISTRAR DATE <b>SEP 14 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
CERTIFICATE OF DEATH

10787

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10768

CERTIFICATE OF DEATH

10761

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, Md.</b> 45 yrs				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, Maryland.</b> 03			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>663 Penna Ave Hagerstown, Md</b>				d. STREET ADDRESS <b>663 Pennsylvania, Ave.</b> 1			
3. NAME OF DECEASED (Type or print) <b>John</b> First <b>Leonard</b> Middle <b>Keats</b> Last				4. DATE OF DEATH <b>Sept</b> Month <b>8</b> Day <b>1960</b> Year			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 27 1914</b> 46 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Aircraft worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fairchild Aircraft</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John H. Keats</b>				14. MOTHER'S MAIDEN NAME <b>Edmonia R. Lewis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-09-2109</b>		17. INFORMANT Address <b>Fannie Keats 663 Penna Ave Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive C.V. Disease; Rheumatic Heart Disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5/8/60</b> 19 to <b>9/8/60</b> 19, that (I) <del>(we)</del> last saw the deceased alive on <b>8/17</b> 1960, and that death occurred at <b>930 P</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Robert V. Campbell</b>				22b. DATE SIGNED <b>9/9/60</b>		22c. PHYSICIAN'S NAME (Type) <b>Robert V. Campbell</b>	
22d. ADDRESS <b>Hagerstown Md</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sep 13/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John R. Watson Jr Hagerstown, Md</b>				25a. REC'D BY REGISTRAR DATE <b>SEP 15 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10769

CERTIFICATE OF DEATH

10762

Item 7 Film 0273 10-19-60 et

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>30 years</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>633 Pennsylvania Ave.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington Co.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b> d. STREET ADDRESS <b>633 Pennsylvania Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Ellen</b> Last <b>Kelsh</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>16</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Color</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 12, 1919</b>
9. AGE (In years lost birthday) <b>41 yrs.</b>		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>11</b> Hours <b>11</b> Min. <b>11</b>	11. IF UNDER 24 HRS. Months <b>11</b> Days <b>11</b> Hours <b>11</b> Min. <b>11</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Amherst, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Huston Slaughter</b>		14. MOTHER'S MAIDEN NAME <b>Florence Grubbs</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-14-2165</b>	
17. INFORMANT <b>Robert Kelsh</b>		Address <b>633 Pennsylvania Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>170X Carcinomatous</b> DUE TO <b>Commons - breast</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs 1 hr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 28 1959</b> to <b>Sept 16 1960</b> , that (I) (we) last saw the deceased alive on <b>Sept 11 1960</b> , and that death occurred at <b>9 P. M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Philip J. Hirshman</b>		22b. DATE SIGNED <b>9/19/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D.</b>		22d. ADDRESS <b>159 W. Washington St., Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept. 20, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John R Watson of Hagerstown Md</b>		25a. REC'D BY REGISTRAR <b>SEP 22 '60</b>	
ADDRESS <b>Hagerstown Md</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

CERTIFICATE OF DEATH

10700

Age

30 years

Married

10700

Color

Color

Color

Color

Color

Color

Color

Color

Color

Color

Color

Color

## CERTIFICATE OF DEATH

10763

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>7 YRS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GATEWAY NURSING HOME</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARY</b> <b>LOUISE</b> <b>KUHN</b>		4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>13</b> Year <b>19 60</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/1/1866</b>
9. AGE (In years lost birthday) <b>94</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE F. BLOOM</b>		14. MOTHER'S MAIDEN NAME <b>CAROLINE SHUPP</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MR. HARRY C. KUHN</b>		<b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>vascular collapse</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>atherosclerotic arteriole disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9/13</b> , 19____, to <b>9/13</b> , 19____, that (I) (we) last saw the deceased alive on <b>9/13</b> , 19____, and that death occurred at <b>1:15 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Howard N. Weeks, M.D.</b>		22b. DATE SIGNED <b>9/14/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Howard N. Weeks, M.D.</b>		22d. ADDRESS <b>136 N. Potomac St., Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>9/15/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM.</b>		23d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Norment</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 15 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Clinton S. Kraus</b>			

CERTIFICATE OF DEATH

1911

WASHINGTON

LOCAL HABITATION

CARETAKER NURSING HOME

LARRY

1911

AGE

CAUSE OF DEATH

NO

LOCALITY

GEORGE F. LIND

CARDIAC DISEASE

NO

MR. HARRY O. LIND

1911

WASHINGTON

LOCAL HABITATION

1911

CARETAKER

AGE

CAUSE OF DEATH

NO

CARDIAC DISEASE

HARRY O. LIND

DECLARATION OF DEATH

DECLARATION OF DEATH

DECLARATION OF DEATH

DECLARATION OF DEATH

DECLARATION OF DEATH



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
10770  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10764

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>1 week</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Olan</b> Last <b>Liskey</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>20</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 20 1888</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	9. AGE (In years lost birthday) <b>71</b> yrs.
11. BIRTHPLACE (State or foreign country) <b>Harrisburg Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>	
13. FATHER'S NAME <b>John Liskey</b>		14. MOTHER'S MAIDEN NAME <b>Katie Ward</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220 30 9183</b>	
17. INFORMANT <b>Mr. Allen F. Liskey</b>		Address <b>Sharpsburg Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio-sclerotic heart disease</b> DUE TO (c) <b>Chronic glomerulo-nephritis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic glomerulo-nephritis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1-14-1960</b> to <b>9-20-1960</b> , that (I) (we) last saw the deceased alive on <b>9-20-1960</b> , and that death occurred at <b>12AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Joseph Secondary</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>JOSEPH SECONDARY</b>		22d. ADDRESS <b>BOONSBORO MD -</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept. 23-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Bakersville Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Bakersville Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Albert Leaf Williamsport, Md</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 26 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

1977

CERTIFICATE OF DEATH

Deceased

Married

Residence

Deceased

Married

Deceased

Deceased

Married

Deceased

Married

Deceased

Deceased

Married

Deceased

Deceased

Married

Deceased

Deceased

Married

Deceased

Deceased

CHIEF

CHIEF

Deceased

Deceased

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10771

## CERTIFICATE OF DEATH

Reg. Dist. No.

10765

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>most of life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>216 Norway Ave.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Clarence Albert Little</b>		4. DATE OF DEATH Month <b>9</b> Day <b>21</b> Year <b>1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 15, 1894</b>
9. AGE (In years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sound Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>self employed</b>	
11. BIRTHPLACE (State or foreign country) <b>Burkittsville, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John William Little</b>		14. MOTHER'S MAIDEN NAME <b>Florence C. Hutts</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-32-5567</b>	
17. INFORMANT <b>Mrs. Agnes Little</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Thrombosis</b> DUE TO (c) <b>Arteriosclerotic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b> <b>5 min</b> <b>1 yr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 21, 1960</b> , to <b>Sept 21, 1960</b> , that I last saw the deceased alive on <b>Sept 21, 1960</b> , and that death occurred at <b>6:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Lloyd A. Hoffman</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>214 N. Potomac St. Hagerstown, Md. 9-22-60</b>	
PHYSICIAN'S NAME (Type) <b>Lloyd A. Hoffman</b>		<b>Hagerstown, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>9-24-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b>		ADDRESS <b>Hagerstown, Md.</b>	
24a. REC'D BY REGISTRAR <b>DAT SEP 26 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraiss</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

10772

10766

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>1 WEEK</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>WASHINGTON</b> Last <b>MAY</b>				4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>17</b> Year <b>19 60</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/11/1880</b>	
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR Months <b>80</b> Days <b>80</b> Hours <b>80</b> Min.		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED CARPENTER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSE CONST.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>WILLIAM MAY</b>				14. MOTHER'S MAIDEN NAME <b>LAURA AMBROSE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MRS. ANNIE V. MAY</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> 420-0 DUE TO (b) <b>Generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic bronchial asthma &amp; bronchitis</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 14, 1953</b> to <b>Sept. 17, 1960</b> that (I) (we) last saw the deceased alive on <b>Sept. 17, 1960</b> and that death occurred <b>9:30 AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>L. L. Parker Jr.</b>				22b. DATE SIGNED <b>9/17/60</b>		22c. PHYSICIAN'S NAME (Type) <b>L. L. Parker Jr. MD</b>	
22d. ADDRESS <b>145 W. Washington St. Hagerstown, Md.</b>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS	
23a. BURIAL, CREMATION, REINTERMENT (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>9/20/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVET CEM.</b>		23d. LOCATION (City, town, or county) (State) <b>FREDERICK MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison</b>				25a. REC'D BY REGISTRAR <b>FREDERICK MD.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kane</b>	

10713

CERTIFICATE OF DEATH

10713

10713

NAME: CHARLES  
AGE: 40  
SEX: M  
RACE: W  
DATE OF BIRTH: 10-10-1913  
PLACE OF BIRTH: [illegible]  
OCCUPATION: [illegible]  
CAUSE OF DEATH: [illegible]  
DATE OF DEATH: 10-10-1953  
PLACE OF DEATH: [illegible]  
SIGNATURE: [illegible]  
TESTAMENTS: [illegible]

[Faint, mostly illegible text and signatures at the bottom of the page, possibly including a witness statement or additional medical notes.]



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

10773										10767			
1													
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>					c. LENGTH OF STAY IN 1b <b>2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>					d. STREET ADDRESS <b>825 Virginia Ave.</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>STEPHEN</b> First <b>CRAIG</b> Middle <b>MAYES</b> Last					4. DATE OF DEATH Month <b>September</b> Day <b>14</b> Year <b>1960</b>								
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 11, 1960</b>		9. AGE (In years last birthday) yrs. <b>2</b>		IF UNDER 1 YEAR Months <b>2</b> Days <b>2</b> Hours <b>2</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Richard Paige Mayes</b>					14. MOTHER'S MAIDEN NAME <b>Esther L. Shaffer</b>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Richard P. Mayes Hagerstown, Maryland</b>								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>776X</b> IMMEDIATE CAUSE (a) <b>Insanity</b> DUE TO <b>Promatency</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Insanity</b> DUE TO (c) <b>Insanity</b>										INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.					20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>9/11/60</b> to <b>9/13/60</b> , that (I) (we) last saw the deceased alive on <b>9/13/60</b> and that death occurred at <b>14</b> M, from the causes and on the date stated above.													
22a. SIGNATURE <b>Howard N. Weeks, M.D.</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>9/16/60</b>						
22c. PHYSICIAN'S NAME (Type) <b>Howard N. Weeks, M.D.</b>					22d. ADDRESS <b>136 N. Potomac St., Hagerstown, Md.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>9/16/1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>			23d. LOCATION (City or town) (County) (State) <b>Hagerstown, Maryland</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>Suter - Rouzer Funeral Home</b>					ADDRESS <b>Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 20 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Carley</b>				

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# CERTIFICATE OF DEATH

10773

(M)

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>Jan 1, 1900</u></p>		<p>4. Date of death: <u>Jan 1, 1980</u></p>	
<p>5. Place of birth: <u>New York, N.Y.</u></p>		<p>6. Place of death: <u>New York, N.Y.</u></p>	
<p>7. Cause of death: <u>Heart disease</u></p>		<p>8. Manner of death: <u>Natural</u></p>	
<p>9. Signature of physician: <u>Dr. J. Doe</u></p>		<p>10. Signature of registrar: <u>John Doe</u></p>	

10774

10768

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		d. STREET ADDRESS <b>522 N. Mulberry</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Wyoma</b> Middle <b>Geneva</b> Last <b>Mentzer</b>		4. DATE OF DEATH Month <b>September</b> Day <b>10</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 24, 1874</b>
9. AGE (In years last birthday) <b>86</b> yrs.		10. IF UNDER 1 YEAR Months <b>86</b> Days <b>86</b> Hours <b>86</b> Min.	11. IF UNDER 24 HRS. Months <b>86</b> Days <b>86</b> Hours <b>86</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Andrew Semler</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Cramer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>---</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>Mrs. Kathryn Shifler</b>		Address <b>Hagerstown Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) <b>1 yr +</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1 yr +</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>o. m.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>JULY 4, 1960</b> to <b>SEPT 10, 1960</b> , that (I) (we) last saw the deceased alive on <b>SEPT 10, 1960</b> , and that death occurred at <b>10</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Clayton C. Hoffman</b>		22b. DATE SIGNED <b>SEPT. 12, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Clayton C. Hoffman</b>		22d. ADDRESS <b>214 N. Potomac St. Hagerstown Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9-13-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Leitersburg Luthern</b>		23d. LOCATION (City, town, or county) (State) <b>Leitersburg Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>		25a. REC'D BY REGISTRAR <b>SEP 14 '60</b>	
ADDRESS <b>Hagerstown Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Hume</b>	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10775

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10769

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN lb <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>420 W. Franklin St.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Frank Charles Miller</b>				4. DATE OF DEATH <b>September 16 19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 5, 1891</b>	9. AGE (In years lost birthday) <b>68</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Metal Stairways</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Charles A. Miller</b>				14. MOTHER'S MAIDEN NAME <b>Mary C. Spielman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Mrs. Edna P. Miller</b>		Address <b>Hagerstown Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>163x</b> IMMEDIATE CAUSE (a) <b>Carcinoma Lung</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (c) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>6 mo</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 1 1960</b> to <b>9-16-60</b> , that (I) (we) lost saw the deceased alive on <b>9-14-60</b> , and that death occurred at <b>3:10a</b> PM, from the causes and on the date stated above.							
22a. SIGNATURE <b>A. E. W. Dittor</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>A. E. W. DITTOR</b>				22d. ADDRESS <b>Hagerstown Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9-19-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>				ADDRESS <b>Hagerstown Md.</b>		25a. REC'D BY REGISTRAR <b>SEP 19 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kneiss</b>			

STATE OF OHIO  
DEPARTMENT OF AGRICULTURE

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Mr. J. Franklin

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
10776  
CERTIFICATE OF DEATH

10770

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN lb <b>11 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>801 Dewery Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>EDNA MAE NICELY</b>		4. DATE OF DEATH Month Day Year <b>Sept. 8 1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feby. 27, 1886</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months Days <b>6 11</b>	
11. IF UNDER 24 HRS. Hours Min. <b>11 11</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Berkley Co W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Scott Emerson</b>		14. MOTHER'S MAIDEN NAME <b>Rose Tabler</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. A. Elizabeth Barton</b>		Address <b>38 Moller Apt. Hag. Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute left ventricular failure (post-operative)</b> DUE TO <b>157X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of pancreas E</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Several hours</b> <b>the known</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4-20 1943</b> to <b>9-8 1960</b> that (I) (we) last saw the deceased alive on <b>9-9 1960</b> , and that death occurred at <b>10:30 p.m.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>John H. Hornbaker</b>		22b. DATE SIGNED <b>SEP 13 60</b>	
22c. PHYSICIAN'S NAME (Type) <b>John H. Hornbaker, M.D.</b>		22d. ADDRESS <b>154 West Washington St., Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept. 11, 60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>River View Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Williamsport Wash. Co Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		25a. REC'D BY REGISTRAR <b>Hagerstown, Md</b>	
25b. REGISTRAR'S SIGNATURE <b>Andrew K. Coffman</b>			



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

10777  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
10771  
CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>PA</u> b. COUNTY <u>FRANKLIN</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GREENCASTLE PA 75X-3</u>	
c. LENGTH OF STAY IN 1b <u>8 days</u>		d. STREET ADDRESS <u>327 East Ball's St</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON Co. HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET R. NICODEMUS</u>		4. DATE OF DEATH Month Day Year <u>Sept 20 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 24 1897</u>
9. AGE (In years lost birthday) yrs. <u>63</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home Keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>ANTRIM TWP PA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>W. S. Rahauer</u>		14. MOTHER'S MAIDEN NAME <u>Susan Wetzel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>184-65-7463</u>	
17. INFORMANT <u>Ralph M. Nicodemus</u>		Address <u>327 E Ball's Greenville PA</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple pulmonary emboli</u> 463X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Probable phlebotrombosis of leg veins</u> DUE TO (c) <u>Unknown</u>			INTERVAL BETWEEN ONSET AND DEATH <u>About 45 min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Marked coronary arteriosclerosis. Diabetes mellitus</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>2:45 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>John H. Hornbaker</u>		22b. DATE SIGNED <u>9:21:60</u>	
22c. PHYSICIAN'S NAME (Type) <u>John H. Hornbaker, M.D.</u>		22d. ADDRESS <u>154 West Washington St., Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		23b. DATE THEREOF <u>SEP 23/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>		23d. LOCATION (City, town, or county) (State) <u>Wagnerstown PA</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>A. E. Munich</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Kline</u>	
ADDRESS <u>Greencastle PA</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	
DATE <u>SEP 26 '60</u>			



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

10772

10778

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN lb <b>56 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>129 E. Washington St.</b>				1. d. STREET ADDRESS <b>129 E. Washington St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charles William Nikirk</b>				4. DATE OF DEATH Month Day Year <b>September 17 1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 19, 1884</b>	9. AGE (In years last birthday) <b>76</b> yrs.	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>m Truck Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery</b>		11. BIRTHPLACE (State or foreign country) <b>Boonesboro Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Charles W. Nikirk</b>				14. MOTHER'S MAIDEN NAME <b>Wilhemina Wallick</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>214-09-7674</b>		17. INFORMANT Address <b>Mrs. Naomi M. Nikirk Hagerstown Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>527.1 Pulmonary Embolism + Fibrinosis</b> DUE TO (b) <b>9 months</b> Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>None</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 1960</b> to <b>Sept. 17 1960</b> , that (I) (we) last saw the deceased alive on <b>Sept 16 1960</b> , and that death occurred at <b>7 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>John D. Turco</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>9-19-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. John D. Turco</b>				22d. ADDRESS <b>302 N. Potomac Street-Hagerstown, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9-20-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Scott F. Minnich &amp; Son Hagerstown Md.</b>				25a. REC'D BY REGISTRAR DATE <b>SEP 22 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoma</b>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10773

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Rhode Island</b> b. COUNTY <b>Providence</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>7 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woonsocket</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Potomac Fish &amp; Game Club</b>				d. STREET ADDRESS <b>474 Fairmount Street</b>			
3. NAME OF DECEASED (Type or print) First <b>ARMAND</b> Middle <b>JOSEPH</b> Last <b>PAGE, SR.</b>				4. DATE OF DEATH Month <b>September</b> Day <b>19</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 31, 1894</b>		9. AGE (In years last birthday) <b>66 yrs.</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Textile Mill</b>		11. BIRTHPLACE (State or foreign country) <b>QUEBEC CANADA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LOUIS PAGE</b>				14. MOTHER'S MAIDEN NAME <b>Vadeboncouer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>036-05-0773</b>		17. INFORMANT Address <b>Armand J. Page, Jr. Funkstown, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerotic Heart Disease</b> (c) <b>Coronary Artery Disease</b> DUE TO cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>A. M. Smith</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>W. E. Smith</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>9/20/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Precious Blood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>WOONSOCKET RHODE ISLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles M. Rouzer</b>				24a. REC'D BY REGISTRAR DATE <b>SEP 23 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



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TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in no event within 72 hours after death.

VR A15 (4)  
ISM 9/59

1  
10780  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10774

1. PLACE OF DEATH a. COUNTY <u>Maryland</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Jackson Convalescent Home</u>				d. STREET ADDRESS <u>711 Oak Hill Ave.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>ANNA</u>		First <u>DORA</u>		Middle <u>POOLE</u>		Lost	
4. DATE OF DEATH		Month <u>September</u>		Day <u>24</u>		Year <u>1960</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 14, 1875</u>		9. AGE (In years lost birthday) <u>84</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Valentine Brewer</u>				14. MOTHER'S MAIDEN NAME <u>Ada ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Dr. Ernest F. Poole</u> Address <u>Hagerstown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>general arteriosclerosis - atherosclerosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>schroter heart disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Calcified heart valve left heart</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 6, 1957</u> to <u>Sept 24, 1960</u> , that (I) (we) last saw the deceased alive on <u>Aug 20, 1960</u> , and that death occurred at <u>10:30 AM</u> , from the causes on and on the date stated above.							
22a. SIGNATURE <u>Edward W. Ditto III</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Edward W. Ditto III, M. D.</u>				22d. ADDRESS <u>217 West Washington Street</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/26/1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Syter - Rouzer Funeral Home</u>				ADDRESS <u>Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 28 '60</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

CERTIFICATE OF DEATH

107-11



*Handwritten signature*

John Doe, deceased

John Doe, deceased

John Doe, deceased

John Doe, deceased

John Doe, deceased

John Doe, deceased

John Doe, deceased



John Doe, deceased

John Doe, deceased

John Doe, deceased

John Doe, deceased

John Doe, deceased

John Doe, deceased

John Doe, deceased

John Doe, deceased

John Doe, deceased

John Doe, deceased

John Doe, deceased





CERTIFICATE OF DEATH

1943

Washington

Married

5 years

Residence

1000 1st Street

Washington, D.C.

Male

White

1900

Age

1943

Year

Month

Married

Married

1000 1st Street

*[Handwritten signature]*

*[Handwritten signature]*

1000 1st Street

1000 1st Street

1000 1st Street



1  
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
10781 CERTIFICATE OF DEATH 302 10776									
1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>					d. STREET ADDRESS <b>745 Spruce St</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLTON NELSON REEDER</b>					4. DATE OF DEATH Month Day Year <b>September 4 1960</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 4 1960</b>		9. AGE (In years lost birthday) yrs. <b>16</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min. <b>16</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Infant</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown Wash Co Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Charles N. Reeder Jr</b>					14. MOTHER'S MAIDEN NAME <b>Virginia Curry</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Charles N. Reeder Jr 745 Spruce St</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>762.0</b> DUE TO <b>Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <b>Hagerstown Md.</b> (c) <b>Interval between onset and death 12 hrs</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>9/4 1960</b> to <b>9/4 1960</b> , that (I) (we) last saw the deceased alive on <b>9/4 1960</b> , and that death occurred at <b>11:00 AM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Richard A. Young</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>9/6/60</b>		
22c. PHYSICIAN'S NAME (Type) <b>Richard A. Young</b>					22d. ADDRESS <b>Hagerstown, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>9/5/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash Co Md.</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>					ADDRESS <b>Hagerstown Md.</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 9 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Charles L. Hines</b>

2081172XV2

10781

CERTIFICATE OF DEATH

10781



Washington County Hospital  
No. 10781  
Date of Death: September 1, 1961  
Age: 75  
Sex: Male  
Race: White  
Marital Status: Married  
Cause of Death: Myocardial Infarction  
Place of Death: Washington County Hospital  
Physician: Dr. J. H. Smith  
Signature: J. H. Smith  
Date: September 1, 1961



Washington County Hospital  
No. 10781  
Date of Death: September 1, 1961  
Age: 75  
Sex: Male  
Race: White  
Marital Status: Married  
Cause of Death: Myocardial Infarction  
Place of Death: Washington County Hospital  
Physician: Dr. J. H. Smith  
Signature: J. H. Smith  
Date: September 1, 1961

CONFIDENTIAL

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10782 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 10777

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>1-HOUR</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BEAR OF PANGBORN CORP. PLANT</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOHN LUTHER RIDENOUR</u>		4. DATE OF DEATH <u>SEPT. 19 - 1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 21 - 1942</u>
9. AGE (In years last birthday) <u>18 yrs.</u>		10. IF UNDER 24 HRS. Months <u>0</u> Days <u>28</u> Hours <u>0</u> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ATTENDANT AT GAS STATION</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>WASH. CO. MD.</u>	
12. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		13. CITIZEN OF WHAT COUNTRY	
14. FATHER'S NAME <u>WELTY RIDENOUR</u>		15. MOTHER'S MAIDEN NAME <u>LEILA SMITH</u>	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		17. SOCIAL SECURITY NO. <u>218-40-2789</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>914.5</u> <u>Electrocution</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Electrocuted while handling electric drill.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>9:30</u> p. m. <u>9-19-60</u> 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>View Street</u>		20f. (City or town) <u>Hagerstown, Washington, Md.</u> (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>A. M. Ditto</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEPT. 22 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MT. LENA CEMETERY</u>		22d. LOCATION (City, town, or county) <u>MT. LENA WASH. CO. MD.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John R. Bart</u>		24. REC'D BY REGISTRAR <u>DATE OCT 3 '60</u>	
ADDRESS <u>BOONSBORO MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>	



NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10-1-1918

NAME OF DECEASED: JOHN J. BOND

AGE: 35 YEARS

SEX: MALE

RACE: WHITE

DATE OF DEATH: 10-1-1918

PLACE OF DEATH: NEW YORK CITY

CAUSE OF DEATH: HEART DISEASE

DATE OF EXAMINATION: 10-1-1918

PLACE OF EXAMINATION: NEW YORK CITY

EXAMINER'S SIGNATURE: [Signature]

DATE OF SIGNATURE: 10-1-1918

OFFICIAL SEAL: [Seal]

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 18 Film 272 10-6-60  
**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RECORDS AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

10783

10778

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>DORCHESTER</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>9 MONTHS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WESTERN MD. STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Kate</b> Middle <b>Robinson</b> Last <b>Robinson</b>				4. DATE OF DEATH Month <b>Sept. 5</b> Day <b>19</b> Year <b>60</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAR. 14, 1882</b>		9. AGE (In years last birthday) <b>78</b> yrs.	10. IF UNDER 1 YEAR Months <b>7</b> Days <b>18</b> Hours <b>18</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Crab Packer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Crabbing</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>George Robbins</b>			
14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <b>3312</b>				17. INFORMANT <b>CLARENCE Robinson</b> Address <b>315 CHARLES ST. SALISBURY, MD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration of vomitus</b> DUE TO <b>cerebro-vascular accident &amp; hemiparesis</b> Conditions, if any, which gave rise to immediate cause (b) <b>general arteriosclerosis</b> cause (c) <b>general arteriosclerosis</b> lying cause lost. <b>10 minutes</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>(1) cardiac hypertrophy (2) chronic pyelonephritis, bil</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 16, 1959</b> to <b>Sept. 5, 1960</b> , that (I) (we) last saw the deceased alive on <b>Sept. 5, 1960</b> , and that death occurred at <b>1:30 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Victor L. Ramos</b>				22b. DATE SIGNED <b>Sept. 5, 1960</b>			
22c. PHYSICIAN'S NAME (Type) <b>VICTOR L. Ramos, M.D.</b>				22d. ADDRESS <b>1500 Pennsylvania Ave, Hagerstown, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<b>BURIAL</b>		<b>SEPT. 7, 1960</b>		<b>Toddville Church Cem.</b>		<b>Toddville Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Thomas F. Hallen</b>				25a. REC'D BY REGISTRAR DATE <b>SEP 8 '60</b>			
25b. REGISTRAR'S SIGNATURE <b>Colleen S. Kraus</b>							



1978

10783

George Robinson  
11/18/27  
11/18/27

George Robinson  
11/18/27  
11/18/27

George Robinson  
11/18/27  
11/18/27



# 1 10779 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10784 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Penna.</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jenkintown</b>	
c. LENGTH OF STAY IN 1b <b>15 days</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		d. STREET ADDRESS <b>Apt. 415 The Benson East</b>	
3. NAME OF DECEASED (Type or print) First <b>Gladys</b> Middle <b>Whiting</b> Last <b>Shelly</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>20</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 24, 1892</b>
9. AGE (In years last birthday) <b>68</b>		IF UNDER 1 YEAR Months <b>75</b> Days <b>x-3</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife and,</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Vice Pres W.H. Whiting Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William H. Whiting</b>		14. MOTHER'S MAIDEN NAME <b>Caroline L. Yager</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>202-07-1080</b>	
17. INFORMANT <b>Mrs. Robert A. Mack, Concord, Massachusetts</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis with Rt. Hemiplegia</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>15 days</b> <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Heart Disease with Coronary Arteriosclerosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9-20</b> , 19 <b>60</b> , to <b>9-20</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>9-20</b> , 19 <b>60</b> , and that death occurred at <b>7:10 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>998 Potomac Avenue</b> DATE SIGNED <b>9-20-60</b>			
ACTUAL SIGNATURE <b>Dalton M. Welty</b> M.D.		PHYSICIAN'S NAME (Type) <b>Dalton M. Welty, M.D.</b> <b>Hagerstown, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/22/1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Green Mount</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur L. Kenna</b>		ADDRESS <b>Waynesboro, Pa.</b>	
24a. REC'D BY REGISTRAR DATE <b>SEP 22 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kenna</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED                  _____</p>		<p>2. SEX                  _____</p>	
<p>3. AGE                  _____</p>		<p>4. DATE OF BIRTH                  _____</p>	
<p>5. PLACE OF BIRTH                  _____</p>		<p>6. DATE OF DEATH                  _____</p>	
<p>7. TIME OF DEATH                  _____</p>		<p>8. PLACE OF DEATH                  _____</p>	
<p>9. CAUSE OF DEATH                  _____</p>		<p>10. MANNER OF DEATH                  _____</p>	
<p>11. SIGNATURE OF PHYSICIAN                  _____</p>		<p>12. SIGNATURE OF REGISTRAR                  _____</p>	
<p>13. SIGNATURE OF WITNESS                  _____</p>		<p>14. SIGNATURE OF DECEASED                  _____</p>	
<p>15. SIGNATURE OF NEXT OF KIN                  _____</p>		<p>16. SIGNATURE OF DECEASED                  _____</p>	
<p>17. SIGNATURE OF DECEASED                  _____</p>		<p>18. SIGNATURE OF DECEASED                  _____</p>	
<p>19. SIGNATURE OF DECEASED                  _____</p>		<p>20. SIGNATURE OF DECEASED                  _____</p>	
<p>21. SIGNATURE OF DECEASED                  _____</p>		<p>22. SIGNATURE OF DECEASED                  _____</p>	
<p>23. SIGNATURE OF DECEASED                  _____</p>		<p>24. SIGNATURE OF DECEASED                  _____</p>	
<p>25. SIGNATURE OF DECEASED                  _____</p>		<p>26. SIGNATURE OF DECEASED                  _____</p>	
<p>27. SIGNATURE OF DECEASED                  _____</p>		<p>28. SIGNATURE OF DECEASED                  _____</p>	
<p>29. SIGNATURE OF DECEASED                  _____</p>		<p>30. SIGNATURE OF DECEASED                  _____</p>	
<p>31. SIGNATURE OF DECEASED                  _____</p>		<p>32. SIGNATURE OF DECEASED                  _____</p>	
<p>33. SIGNATURE OF DECEASED                  _____</p>		<p>34. SIGNATURE OF DECEASED                  _____</p>	
<p>35. SIGNATURE OF DECEASED                  _____</p>		<p>36. SIGNATURE OF DECEASED                  _____</p>	
<p>37. SIGNATURE OF DECEASED                  _____</p>		<p>38. SIGNATURE OF DECEASED                  _____</p>	
<p>39. SIGNATURE OF DECEASED                  _____</p>		<p>40. SIGNATURE OF DECEASED                  _____</p>	
<p>41. SIGNATURE OF DECEASED                  _____</p>		<p>42. SIGNATURE OF DECEASED                  _____</p>	
<p>43. SIGNATURE OF DECEASED                  _____</p>		<p>44. SIGNATURE OF DECEASED                  _____</p>	
<p>45. SIGNATURE OF DECEASED                  _____</p>		<p>46. SIGNATURE OF DECEASED                  _____</p>	
<p>47. SIGNATURE OF DECEASED                  _____</p>		<p>48. SIGNATURE OF DECEASED                  _____</p>	
<p>49. SIGNATURE OF DECEASED                  _____</p>		<p>50. SIGNATURE OF DECEASED                  _____</p>	
<p>51. SIGNATURE OF DECEASED                  _____</p>		<p>52. SIGNATURE OF DECEASED                  _____</p>	
<p>53. SIGNATURE OF DECEASED                  _____</p>		<p>54. SIGNATURE OF DECEASED                  _____</p>	
<p>55. SIGNATURE OF DECEASED                  _____</p>		<p>56. SIGNATURE OF DECEASED                  _____</p>	
<p>57. SIGNATURE OF DECEASED                  _____</p>		<p>58. SIGNATURE OF DECEASED                  _____</p>	
<p>59. SIGNATURE OF DECEASED                  _____</p>		<p>60. SIGNATURE OF DECEASED                  _____</p>	
<p>61. SIGNATURE OF DECEASED                  _____</p>		<p>62. SIGNATURE OF DECEASED                  _____</p>	
<p>63. SIGNATURE OF DECEASED                  _____</p>		<p>64. SIGNATURE OF DECEASED                  _____</p>	
<p>65. SIGNATURE OF DECEASED                  _____</p>		<p>66. SIGNATURE OF DECEASED                  _____</p>	
<p>67. SIGNATURE OF DECEASED                  _____</p>		<p>68. SIGNATURE OF DECEASED                  _____</p>	
<p>69. SIGNATURE OF DECEASED                  _____</p>		<p>70. SIGNATURE OF DECEASED                  _____</p>	
<p>71. SIGNATURE OF DECEASED                  _____</p>		<p>72. SIGNATURE OF DECEASED                  _____</p>	
<p>73. SIGNATURE OF DECEASED                  _____</p>		<p>74. SIGNATURE OF DECEASED                  _____</p>	
<p>75. SIGNATURE OF DECEASED                  _____</p>		<p>76. SIGNATURE OF DECEASED                  _____</p>	
<p>77. SIGNATURE OF DECEASED                  _____</p>		<p>78. SIGNATURE OF DECEASED                  _____</p>	
<p>79. SIGNATURE OF DECEASED                  _____</p>		<p>80. SIGNATURE OF DECEASED                  _____</p>	
<p>81. SIGNATURE OF DECEASED                  _____</p>		<p>82. SIGNATURE OF DECEASED                  _____</p>	
<p>83. SIGNATURE OF DECEASED                  _____</p>		<p>84. SIGNATURE OF DECEASED                  _____</p>	
<p>85. SIGNATURE OF DECEASED                  _____</p>		<p>86. SIGNATURE OF DECEASED                  _____</p>	
<p>87. SIGNATURE OF DECEASED                  _____</p>		<p>88. SIGNATURE OF DECEASED                  _____</p>	
<p>89. SIGNATURE OF DECEASED                  _____</p>		<p>90. SIGNATURE OF DECEASED                  _____</p>	
<p>91. SIGNATURE OF DECEASED                  _____</p>		<p>92. SIGNATURE OF DECEASED                  _____</p>	
<p>93. SIGNATURE OF DECEASED                  _____</p>		<p>94. SIGNATURE OF DECEASED                  _____</p>	
<p>95. SIGNATURE OF DECEASED                  _____</p>		<p>96. SIGNATURE OF DECEASED                  _____</p>	
<p>97. SIGNATURE OF DECEASED                  _____</p>		<p>98. SIGNATURE OF DECEASED                  _____</p>	
<p>99. SIGNATURE OF DECEASED                  _____</p>		<p>100. SIGNATURE OF DECEASED                  _____</p>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

10803

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10780

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c. LENGTH OF STAY IN 1b <u>13 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Big Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>				d. STREET ADDRESS <u>NONE</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ada</u> Middle <u>V.</u> Last <u>Smith</u>				4. DATE OF DEATH Month <u>September</u> Day <u>13</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 2, 1877</u>	
9. AGE (In years lost birthday) <u>83</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>Big Spring</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Kuhn</u>				14. MOTHER'S MAIDEN NAME <u>Mahala Brewer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>MISS HELEN K. SMITH</u>		Address <u>BIG SPRING, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>443X</u> DUE TO <u>Cerebral Hemorrhage with Hemiplegia</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <u>Hypertensive Arteriosclerotic Heart Disease</u> (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>15 days</u> <u>15 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u> <u>CARCINOMA OF THE RECTUM</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>August 28, 1960</u> to <u>September 13, 1960</u> , that (I) (we) lost saw the deceased alive on <u>Sept. 13</u> , and that death occurred at <u>4:40 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Archie Robert Cohen</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Sept. 14, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>Archie Robert Cohen, M.D.</u>				22d. ADDRESS <u>Clear Spring, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>SEPT. 16, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL, CLSPG. MD.</u>		23d. LOCATION (City, town, or county) (State) <u>CLEAR SPRING, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Clark</u>				ADDRESS <u>CLEAR SPRING, MD.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 19 '60</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

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CERTIFICATE OF DEATH

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>									
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Washington</b> <b>MARYLAND</b>					<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			c. LENGTH OF STAY IN lb <b>most of life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Western Maryland State Hospital</b>					d. STREET ADDRESS <b>4424 W. Church Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Gertrude</b> Middle <b>Edith</b> Last <b>SMITH</b>					<b>4. DATE OF DEATH</b> Month <b>9</b> Day <b>30</b> Year <b>1960</b>				
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>February 4, 1882</b>		<b>9. AGE</b> (In years last birthday) <b>78</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	<b>IF UNDER 24 HRS.</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>New Oxford, Pennsylvania</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		
<b>13. FATHER'S NAME</b> <b>Abram Stambaugh</b>					<b>14. MOTHER'S MAIDEN NAME</b> <b>Emily Kepner</b>				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>none</b>		<b>17. INFORMANT</b> <b>James W. Smith</b>			<b>Address</b> <b>Hagerstown, Maryland</b>		
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subacute Pyelonephritis</b> DUE TO <b>Rheumatoid arthritis, multiple.</b> (b) <b>13 years</b> DUE TO (c)								<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>6 months</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>Pulmonary emboli. Coronary atherosclerosis</b>									
<b>20a. ACCIDENT WAS UNDERWAY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)						
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)		
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>Sept. 17, 1960</b> <b>to</b> <b>Sept. 30, 1960</b> , <b>that (I) (we) lost saw the deceased alive on</b> <b>Sept. 30, 1960</b> <b>and that death occurred on</b> <b>Sept. 30, 1960</b> , <b>from the causes and on the date stated above.</b>									
<b>22a. SIGNATURE</b> <b>Young E. Chun</b>					<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>Sept. 30, 1960</b>		
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Dr. Young E. Chun</b>					<b>22d. ADDRESS</b> <b>1500. Penna. Ave, Hagerstown, Md.</b>				
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>			<b>23b. DATE THEREOF</b> <b>10/3/1960</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Rest Haven Cemetery</b>		<b>23d. LOCATION</b> (City, town, or county) (State) <b>Hagerstown Maryland</b>		
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Suter - Rouzer Funeral Home</b> <b>H. Franklin Rouzer</b>					<b>ADDRESS</b> <b>Hagerstown, Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE OCT 3 '60</b>		
					<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>				

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• *Not a member of the Society?*





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CERTIFICATE OF DEATH

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Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to blurring and bleed-through from the reverse side.

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CHIEF CLERK

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VP A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10814

CERTIFICATE OF DEATH

10783

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown Rt. #4</b> c. LENGTH OF STAY IN 1b <b>Hagerstown</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Broadforeing Road</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>PAUL</b> Middle <b>ELMER</b> Last <b>SPRECHER</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>9</b> Year <b>1960</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 15, 1892</b>	9. AGE (In years last birthday) <b>67</b> yrs.	IF UNDER 1 YEAR Months <b>8</b> Days <b>24</b> Hours <b></b> Min. <b></b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Willsons Wash. Co Md</b>			
13. FATHER'S NAME <b>John Sprepher</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Zentmyer</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Hagerstown Md. Rt. #4</b> <b>Mrs. Myrtle L. Sprecher</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420-1</b> <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Gen Arterio sclerosis</b> DUE TO (c) <b></b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b> INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>7-1-60</b> to <b>9-9-1960</b> , that (I) (we) last saw the deceased alive on <b>9-7-60</b> , and that death occurred <b>22:00</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>A. E. W. Dittus Jr</b>		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <b>A. E. W. Dittus Jr</b>			
22d. ADDRESS <b>Hagerstown Md</b>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/12/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Pauls Cemetery</b>			
23d. LOCATION (City, town, or county) <b>Wash Co Md</b>		23e. (State)					
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		ADDRESS <b>Hagerstown Md.</b>		25a. REC'D BY REGISTRAR <b>SEP 13 '60</b>			
25b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>							

CERTIFICATE OF DEATH

10812

(M)

Residence: Boston, Massachusetts  
Date of Birth: Dec. 12, 1885  
Place of Birth: U.S.A.  
Cause of Death: Coronary Artery Disease  
Date of Death: Dec. 12, 1965  
Time of Death: 10:30 A.M.  
Place of Death: Home  
Physician: Dr. J. H. Smith  
Burial Place: St. Paul's Cemetery, Boston, Mass.

*[Faint, illegible text, likely bleed-through from the reverse side of the document]*

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DR. BELL  
119 N. POTOMAC ST  
10815  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
10784

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FUNKSTOWN</b>				c. LENGTH OF STAY IN 1b <b>33 YEARS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>239 EAST BALTIMORE ST</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>MARGARET F. STEEN</b>				4. DATE OF DEATH <b>SEPTEMBER 25, 1960</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DECEMBER 18, 1877</b>	
9. AGE (In years last birthday) <b>82</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		11. BIRTHPLACE (State or foreign country) <b>WELSH RUN</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHRISTIAN MARKOTTE</b>				14. MOTHER'S MAIDEN NAME <b>NANCY SHAFER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>JOHN W. STEEN FUNKSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Cerebral Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease.</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>  <b>Years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 15, 1960</b> to <b>Sept. 25, 1960</b> , that (I) (we) last saw the deceased alive on <b>Sept. 25, 1960</b> , and that death occurred at <b>5 P</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>R.A. Bell</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>9-27-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>R.A. Bell, M.D.</b>				22d. ADDRESS <b>Hagerstown, Maryland.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>SEPT. 28, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FUNKSTOWN CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>FUNKSTOWN WASH. CO. MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Best</b>				ADDRESS <b>BOONSBORO MD</b>		25. REC'D BY REGISTRAR DATE <b>OCT 3 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

10522

CERTIFICATE OF DEATH

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WASHINGTON

WASHINGTON

35 YEARS

35 YEARS

239 EAST CAPITOL HILL, WASHINGTON, D.C.

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WHITE

OWN HOME

CHRISTIAN MARQUETTE

WIFE

DECEASED

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

302

10785

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>20 Yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>534 Pangborn Blvd</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>GEORGE EDWARD STONEBRAKER</b>		4. DATE OF DEATH Month Day Year <b>September 2 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 28 1881</b>
9. AGE (In years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrical Engineer Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Downsville Wash Co Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>D. Huyett stonebraker</b>		14. MOTHER'S MAIDEN NAME <b>Frances Rowland</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-16-5314</b>	
17. INFORMANT <b>Mrs Viola H. Stonebraker</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary artery disease</b> (c) <b>14yr</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>534 Pangborn Blvd Hagerstown Md.</b> ONSET AND DEATH <b>5 min</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9-2</b> 19 <b>60</b> , to <b>9-2</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred <b>about</b> AM, from the causes and on the date stated above.			
22a. SIGNATURE <b>Paul Harrison</b>		22b. DATE SIGNED <b>9-3-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Paul Harrison, M.D.</b>		22d. ADDRESS <b>315 N. Potomac St., Hagerstown Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/5/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash Co Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 9 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>			

10735

CERTIFICATE OF DEATH

10736

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 17, MARYLAND

10787

CERTIFICATE OF DEATH

302

10786

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash county hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b> d. STREET ADDRESS <b>411 West Washington St</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JANE ELIZABETH STOTELMYER</b>				4. DATE OF DEATH Month <b>Sept</b> Day <b>14</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 4 1960</b>	
9. AGE (In years last birthday) yrs. <b>2</b>		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>10</b> Hours <b></b> Min. <b></b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown Wash Co Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Lewis Stotelmyer Jr</b>				14. MOTHER'S MAIDEN NAME <b>Frances Whorton</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Lewis V. Stotelmyer Jr</b> Address <b>411 W. Washington St Hagerstown Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary failure</b> <b>053.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Septicemia</b> DUE TO (c) <b></b>				INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>5 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from _____ 19____, to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Richard A. Young</b>				22b. DATE SIGNED <b>9/15/60</b>		22c. PHYSICIAN'S NAME (Type) <b>Richard A. Young</b>	
22d. ADDRESS <b>101 King St. Hagerstown Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/16/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash Co Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b> ADDRESS <b>Hagerstown Md.</b>				25a. REC'D BY REGISTRAR <b>SEP 19 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

type of argument

1  
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
10788  
CERTIFICATE OF DEATH  
302  
10787

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		d. STREET ADDRESS <b>1310 Bryan Place</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CECILE ELLA STOTLER</b>		4. DATE OF DEATH <b>September 28 1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 21 1895</b>
9. AGE (In years lost birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown Wash Co Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John E. Stotler</b>		14. MOTHER'S MAIDEN NAME <b>Lutie V. Summers</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>-----</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Daniel O. Stotler</b>		Address <b>147 Belview Ave</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma - right breast with metastasis to chest - spine - right femur</b> DUE TO (b) <b>2 1/2 yrs.</b> DUE TO (c) <b>Spine - right femur</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hagerstown Md.</b>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 4 1960</b> to <b>Sept 28 1960</b> , that (I) (we) last saw the deceased alive on <b>Sept 27 1960</b> , and that death occurred at <b>2:15 M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Edward W. Dittus III, M.D.</b>		22b. DATE SIGNED <b>9/29/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>EDWARD W. DITTUS III, M.D.</b>		22d. ADDRESS <b>217 WEST WASHINGTON ST.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/30/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash Co Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		25. REC'D BY REGISTRAR <b>OCT 3 '60</b>	
ADDRESS <b>Hagerstown Md</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

CERTIFICATE OF DEATH

10788

(M)

Washington County, Maryland

Washington

Washington County, Maryland

STONER

ELBA

CECILE

June 12, 1935

Female, White

Washington County, Maryland

One Son

Married

June 12, 1935

John E. Stoner

John E. Stoner and Mary Jane

Sons

Washington County, Maryland

Washington County, Maryland

Washington County, Maryland

Washington County, Maryland

7/11/35

John E. Stoner

Washington County, Maryland

Washington County, Maryland

Washington County, Maryland



1  
TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
10816  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10788

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hancock</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b> 0102-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Hancock Rest Home</b>		d. STREET ADDRESS <b>103 Race St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Ida</b> Last <b>Stotler</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>8</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 10, 1867</b>
9. AGE (In years lost birthday) <b>92</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Berkeley Co., W.Va.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas Myers</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Nornton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. B. Britt</b>		Address <b>Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized arteriosclerosis</b> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>year</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 60</b> to <b>Sept 8 60</b> , that (I) (we) last saw the deceased alive on <b>Aug 28 19 60</b> , and that death occurred at <b>11</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>B. M. Schindler</b>		22b. DATE SIGNED <b>SEP 10 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. B.M. Schindler</b>		22d. ADDRESS <b>43 Greene Street Cumberland, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9-12-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Greenway</b>		23d. LOCATION (City, town, or county) (State) <b>Berkeley Springs, W. Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James B. Hunter</b>		25a. REC'D BY REGISTRAR <b>SEP 14 '60</b>	
ADDRESS <b>Berkeley Springs, W. Va.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles E. Hume</b>	

19816

CENTRAL OF DEATH

11-502

Washington

Allegany

Hancock

2 yrs.

Underland

Hancock West Home

103 West St.

Mary

103

Scottier

Sgt. J.

Female White

Sgt. J. 1907

32

Honolulu

Berkley No. 1 W. Va.

USA

Mary Thomas Evans

Sarah Morrison

Hone

Mrs. J. E. E. E. E.

Hampden, N.Y.



*[Faint, mostly illegible text and signatures at the bottom of the page, possibly bleed-through from the reverse side.]*

TO DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10789

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Weverton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Hook (Rural)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Route #340		d. STREET ADDRESS RFD # 1, Knoxville, Md.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last WAYNE WILLIAM TRIBBY		4. DATE OF DEATH September 8, 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 4, 1942
9. AGE (In years last birthday) 18 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Helper		10b. KIND OF BUSINESS OR INDUSTRY Y.M.C.A.	
11. BIRTHPLACE (State or foreign country) Knoxville, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Levin West Tribby		14. MOTHER'S MAIDEN NAME Mabel Loretta Deaner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-40-2897	
17. INFORMANT Mrs. Levin Tribby Address RFD # 1, Knoxville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture Skull DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH Instant	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck stone buttress while driving west on State R # 340	
20c. TIME OF INJURY Month, Day, Year Hour min. 11:50 a. m. 9-8-1960		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) State R # 340		20f. (City or town) Weverton, Washington, Maryland (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Dr. E. W. Ditto, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/11/60	
22c. NAME OF CEMETERY OR CREMATORY Brownsville Hgts. Cemetery, Brownsville, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE R. Donald Lockles		24a. REC'D BY REGISTRAR DATE SEP 13 '60	
		24b. REGISTRAR'S SIGNATURE R. L. S. H. H. H.	



TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

107889

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10790

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown Maryland</b>				c. LENGTH OF STAY IN 1b <b>7Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Samuel</b> Middle <b>Paul</b> Last <b>Turner</b>				4. DATE OF DEATH Month <b>9</b> Day <b>15</b> Year <b>19 60</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>9.8.1910</b>		9. AGE (In years lost birthday) yrs. <b>50</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Harrisonburg VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Turner</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Smith</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>094-10-9874</b>		17. INFORMANT <b>Mildred J Turner Hancock Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.0</b> IMMEDIATE CAUSE (a) <b>Infarction of myocardium</b> DUE TO (b) <b>Arteriosclerotic coronary thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>Arteriosclerotic heart disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>8 hour</b> <b>Days</b> <b>Indefinite</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 8, 1960</b> to <b>Sept 15, 1960</b> , that (I) (we) lost saw the deceased alive on <b>Sept 15, 1960</b> , and that death occurred at <b>11 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>R.S. Stauffer</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Sept. 16, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>R.S. STAUFFER</b>				22d. ADDRESS <b>Hagerstown, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9.18.60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oliver Grove Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Oldtown Allegany Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>				ADDRESS <b>Cumberland, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 19 '60</b>	
						25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

081

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G271 9-13-60 et

10802

## CERTIFICATE OF DEATH

Reg. Dist. No.

10791

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boonsboro</b>		c. LENGTH OF STAY IN 1b <b>3 1/2 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Reeder Nursing Home</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X rural Smithsburg</b>	
		d. STREET ADDRESS <b>1 RFD 1</b>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Luella</b> Middle <b>Elizabeth</b> Last <b>Unger</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>5</b> Year <b>1960</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1873</b>
9. AGE (In years lost birthday) <b>87</b> yrs.		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>14</b> Hours <b>18</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Smithsburg, Md.</b>	
11. BIRTHPLACE (State of foreign country) <b>Smithsburg, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>J. Leonard Vogel</b>		14. MOTHER'S MAIDEN NAME <b>Amanda Siglen</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Leonard W. Unger, Hagerstown, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized arteriosclerosis</b> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 10, 1960</b> , to <b>Sept 5, 1960</b> , that I last saw the deceased alive on <b>Sept 2, 1960</b> and that death occurred at <b>11 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Boonsboro, Md.</b> DATE SIGNED <b>9/6/60</b> ACTUAL SIGNATURE <b>G. W. Lellan</b> M.D. PHYSICIAN'S NAME (Type) <b>G. W. Lellan</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>9-8-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Smithsburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Smithsburg, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 9 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

CERTIFICATE OF DEATH

1904



John

1904

Washington

Smithsburg

1904

21 years

Boonville

Boonville

1904

Sept. 5, 1904

Under

Smithsburg

Boonville

Jan. 14, 1904

Female white

Smithsburg, Md.

Boonville

Anna Maria

J. Leonard Vogel

Leonard A. Vogel, Hagerstown, Md.

none

no

Smithsburg, Md.

Smithsburg Cemetery

1904

Boonville

George F. Smith & Son, Smithsburg, Md.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10790

CERTIFICATE OF DEATH

10792

Items 11, 12 Film 0271 9-19-60 et

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>5 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Western Md. State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Maizie</b> Middle <b>Myrtle</b> Last <b>Vance</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>8</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 14, 1884</b>
9. AGE (In years last birthday) <b>76 yrs.</b>		10. IF UNDER 1 YEAR Months <b>76</b> Days <b>76</b> Hours <b>76</b> Min. <b>76</b>	11. IF UNDER 24 HRS. Months <b>76</b> Days <b>76</b> Hours <b>76</b> Min. <b>76</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>---</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
11. BIRTHPLACE (State or foreign country) <b>Unknown Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David Vance</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Shedrach</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>---</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>Mrs. Carrie J. Vance</b>		Address <b>Hagerstown Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rt. coronary occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>atherosclerosis</b> DUE TO (c) <b>---</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b> <b>unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Gold posterior myocardial infarction @ CVA &amp; hemiparesis</b>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>---</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>---</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>---</b>	20f. (City or town) (County) (State) <b>---</b>
21. I certify that (I) (this hospital) attended the deceased from <b>April 21, 1960</b> , to <b>Sept. 8, 1960</b> , that (I) (we) last saw the deceased alive on <b>Sept. 8, 1960</b> , and that death occurred at <b>9:30 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Victor L. Ramos, M.D.</b>		22b. DATE SIGNED <b>Sept. 8, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Victor L. Ramos, M.D.</b>		22d. ADDRESS <b>Western Md. State Hospital, Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>9-8-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>		25a. REC'D BY REGISTRAR <b>Hagerstown Md.</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>		DATE <b>SEP 13 '60</b>	



091

1

2

1

AP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10791

## CERTIFICATE OF DEATH

10793

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
c. LENGTH OF STAY IN 1b <u>10dys /</u>				d. STREET ADDRESS <u>144 N. Popomac Street</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED First <u>Alice</u> Middle <u>Weagley</u> Last <u>Wagner</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>16</u> Year <u>19 60</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 6, 1880</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner Operator Speciality Shop</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Cavetown, Wash. Cty., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Theodore Weagley</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Winters</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Louise Weagley, Middletown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolus</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Thrombophlebitis, pelvic</u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Squamous cell carcinoma, right lung with recurrent pleural effusion</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. 9.</u> Month <u>  </u> Day <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Sept. 7th</u> , 19 <u>60</u> , to <u>Sept. 16</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Sept. 16</u> , 19 <u>60</u> , and that death occurred at <u>7:40 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John H. Kehne M.D.</u>				ADDRESS (Street, city or town, state) <u>131 W. Washington Street, Hagerstown, Md.</u>			
PHYSICIAN'S NAME (Type) <u>John H. Kehne M.D.</u>				DATE SIGNED <u>Sept. 17, 1960</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/19/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Cty., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman, Hagerstown, Md.</u>				24a. REC'D BY REGISTRAR <u>SEP 20 '60</u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	





TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
MARYLAND STATE BOARD OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
10792  
CERTIFICATE OF DEATH

10794

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Washington County Hospital</b>		e. STREET ADDRESS <b>Williamsport R#2</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Catherine Ellen Nettie Watkins</b>		4. DATE OF DEATH Month Day Year <b>Sept. 17 19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 18, 1907</b>
9. AGE (In years last birthday) <b>52</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Luther M. Stoner</b>		14. MOTHER'S MAIDEN NAME <b>Anna L. Metzger</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Frank F. Watkins</b>		Address <b>R#2 Williamsport, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420 - 1</b> DUE TO <b>Ac. myocardial infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <b>10 days</b> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9/17/60</b> to <b>9/17/60</b> that (I) (we) last saw the deceased alive on <b>9/17/60</b> and that death occurred at <b>3:30 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Ralph F. Young</b>		22b. DATE SIGNED <b>9/18/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Ralph F. Young M.D.</b>		22d. ADDRESS <b>101 E. Potomac St. Williamsport, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE OF DEATH <b>9/21/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel</b>		ADDRESS <b>Hagerstown, Md.</b>	
25a. REC'D BY REGISTRAR DATE <b>SEP 21 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

Wm. C. Host

CERTIFICATE OF ORIGIN

10732



THIS CERTIFICATE OF ORIGIN is issued to the owner of the following animal, to certify that the animal is free from all communicable diseases, and is fit for exportation.

Animal: *10732*  
Breed: *White*  
Age: *1 year*  
Sex: *Male*  
Color: *White*  
Markings: *None*  
Date of birth: *1910*  
Place of birth: *Illinois*  
Owner: *John A. Smith*  
Address: *1234 Main St., Chicago, Ill.*  
Signature: *John A. Smith*  
Date: *Jan 1, 1911*

*10732*  
*White*  
*1 year*  
*Male*  
*White*  
*None*  
*1910*  
*Illinois*  
*John A. Smith*  
*1234 Main St., Chicago, Ill.*  
*John A. Smith*  
*Jan 1, 1911*

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

107933

107933  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10795

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>2 mos 22 das</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 HAGERSTOWN</b>		d. STREET ADDRESS <b>1217 W WASHINGTON STREET</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WESTERN MARYLAND STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Earl</b> Middle <b>G.</b> Last <b>WATSON</b>		4. DATE OF DEATH Month <b>9</b> Day <b>1</b> Year <b>1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 21 1882</b>
9. AGE (In years, last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>METER TESTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MUNICIPALITY</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES M WATSON</b>		14. MOTHER'S MAIDEN NAME <b>ANNA BRENNER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220-34-0753</b>	
17. INFORMANT <b>MISS HELEN B WATSON</b>		Address <b>HAGERSTOWN MARYLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobular Pneumonia</b> DUE TO <b>182-1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bronchogenic Carcinoma of lung</b> DUE TO <b>6 months</b> (c) <b>2 weeks</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchiectasis, Right lung</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 9, 1960</b> to <b>Sept. 1, 1960</b> that (I) (we) last saw the deceased alive on <b>Sept. 1, 1960</b> and that death occurred at <b>11:45 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Young E. Chun</b>		22b. DATE SIGNED <b>Sept. 1, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Young E. Chun</b>		22d. ADDRESS <b>1500 Penn. Ave Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>9/3/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>REST HAVEN CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MARYLAND</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles M. Kruger</b>		25a. REC'D BY REGISTRAR <b>SEP 6 '60</b>	
ADDRESS <b>HAGERSTOWN MARYLAND</b>		25b. REGISTRAR'S SIGNATURE <b>Charles L. Kruger</b>	

10717

CERTIFICATE OF DEATH

10793

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
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10794

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10796

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>4 Mo-7 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Western Maryland State Hospital</b>		d. STREET ADDRESS <b>517 Greene Street</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>John Lawrence WAYS</b>		4. DATE OF DEATH Month Day Year <b>9 4 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 11, 1897</b>
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) <b>Linotype operator- Cumberland Times</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel D. Ways</b>		14. MOTHER'S MAIDEN NAME <b>Barbara Wiegand</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-05-4913</b>	
17. INFORMANT <b>Mrs. Edith A. Ways</b>		517 Greene Street, Cumberland, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobular pneumonia</b> DUE TO (b) <b>glioma, left hemisphere</b> DUE TO (c) <b>over 1 year</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Atrial fibrillation</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 28</b> 19 <b>60</b> to <b>Sept. 4</b> 19 <b>60</b> that (I) (we) last saw the deceased alive on <b>Sept. 4</b> 19 <b>60</b> and that death occurred at <b>6:15 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Young E. Chun</b>		22b. ADDRESS <b>1500 Penna. Ave. Hagerstown, Md.</b>	
22c. PHYSICIAN'S NAME (Type) <b>Young E. Chun</b>		22d. ADDRESS <b>1500 Penna. Ave. Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/7/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Cumberland Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>H. Lee Silcox</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	
24a. ADDRESS <b>Cumberland Maryland</b>		25a. REC'D BY REGISTRAR <b>SEP 7 '60</b>	

BP

CERTIFICATE OF DEATH

WE, the undersigned, being a duly qualified Medical Officer of Health for the District of ...

Age ...

Sex ...

Occupation ...

Residence ...

Number of ...

Age ...

Sex ...

ST. ...

ST. ...

John Lawrence Wap

June 11, 1917

Male

Married

Married

Married

Married

ST. ...

ST. ...

John Lawrence Wap

John Lawrence Wap

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John Lawrence Wap



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/59

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10795

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

302

10797

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>8 Yrs</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>801 Mulberry Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ALLIE May WELTY</b>		4. DATE OF DEATH Month Day Year <b>September 23 1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 15 1879</b>
9. AGE (In years lost birthday) <b>81</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>	
11. BIRTHPLACE (State or foreign country) <b>Paramount Wash Co Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Lohr</b>		14. MOTHER'S MAIDEN NAME <b>Barbara Clopper</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT Address <b>Miss Leola Lohr 801 Mulberry Ave</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Breast</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost, (b) DUE TO (c) <b>Hagerstown Md.</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3-20</b> , 19 <b>51</b> , to <b>9-23</b> , 19 <b>60</b> that (I) (we) last saw the deceased alive on <b>9-23</b> , 19 <b>60</b> , and that death occurred at <b>12</b> M., from the causes and on the date stated above.			
22a. SIGNATURE <b>Dalton M. Welty</b>		22b. DATE SIGNED <b>9-23-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dalton M. Welty, M.D.</b>		22d. ADDRESS <b>998 Rt. 206 Ave., Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/24/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash Co Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Andrew K. Coffman Hagerstown Md.</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 26 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

10737

WARRANTY OF SERVICE OF DEATH  
IN THE DISTRICT COURT OF THE STATE OF TEXAS  
COUNTY OF DALLAS

10737

(M)

DECEASED: [Name] [Address] [City] [State] [Zip]  
[Name] [Address] [City] [State] [Zip]

801 Liberty Ave  
[Name] [Address] [City] [State] [Zip]

WITNESSES: [Name] [Address] [City] [State] [Zip]  
[Name] [Address] [City] [State] [Zip]

June 15 1977  
[Name] [Address] [City] [State] [Zip]

Notary Public for the State of Texas  
[Name] [Address] [City] [State] [Zip]

Witnessed by:  
[Name] [Address] [City] [State] [Zip]

1001 Lee Road  
[Name] [Address] [City] [State] [Zip]

Notary Public for the State of Texas  
[Name] [Address] [City] [State] [Zip]

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[Name] [Address] [City] [State] [Zip]

[Name] [Address] [City] [State] [Zip]

[Name] [Address] [City] [State] [Zip]

[Name] [Address] [City] [State] [Zip]

[Name] [Address] [City] [State] [Zip]

[Name] [Address] [City] [State] [Zip]

[Name] [Address] [City] [State] [Zip]

[Name] [Address] [City] [State] [Zip]

[Name] [Address] [City] [State] [Zip]

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10798

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>1 week 1 day</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsport Md (Rural) RFD #1</b> d. STREET ADDRESS <b>Williamsport Md RFD #1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ronald</b> Middle <b>Jay</b> Last <b>Whipp</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>30</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 22 1960</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Charles Whipp</b>		14. MOTHER'S MAIDEN NAME <b>Phyllis Whittington</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. Charles Whipp</b> Address <b>Williamsport Md. RFD #1</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-Respiratory arrest</b> DUE TO <b>Prematurity + Esophageal atresia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>56.2</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 min</b> <b>5 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Post-ob weekness</b> (b) <b>? of Small Bowel obstruction</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9-22-60</b> to <b>9-30-60</b> , that (I) (we) last saw the deceased alive on <b>9-29-60</b> , and that death occurred at <b>7:15</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>M.E. Byrkit</b>		22b. DATE SIGNED <b>9-30-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>M.E. Byrkit</b>		22d. ADDRESS <b>28 W Potomac Wmpt Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct. 2 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Williamsport Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Armal Button</b> ADDRESS <b>Williamsport, Md</b>		25a. REC'D BY REGISTRAR <b>DATE OCT 3 '60</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles S. Kinn</b>	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

10797

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1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>2 WEEKS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. CO. HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Patricia Ann Wolff</u>		4. DATE OF DEATH <u>September 2 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL-6-1956</u>
9. AGE (In years last birthday) <u>4</u> yrs.		10. IF UNDER 1 YEAR <u>4</u> Months <u>26</u> Days <u></u> Hours <u></u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>HAGERSTOWN WASH. CO. MD. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>NO RECORD</u>		14. MOTHER'S MAIDEN NAME <u>NAOMI VIRGINIA WOLFF</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS. MERUE CLIPP</u>		Address <u>KEEDYSVILLE MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypogammaglobulinemia</u> <u>759.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Pneumonia - Viral</u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>Life.</u> <u>1 week</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 2, 1958</u> to <u>Sept. 2, 1960</u> , that (I) (we) last saw the deceased alive on <u>Sept. 1, 1960</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>G. W. Helvan</u>		22b. DATE SIGNED <u>Sept 4 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. W. Helvan</u>		22d. ADDRESS <u>Boonsboro Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>SEPT. 4. 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO WASH. CO. MD. CEMETERY</u>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Best</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 14 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>			

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CERTIFICATE OF DEATH

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10798 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10801

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL (D.O.A.)</b>				d. STREET ADDRESS <b>428 Belvedere Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>THOMAS</b> Last <b>YOST</b>				4. DATE OF DEATH Month <b>SEPT.</b> Day <b>30</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 5 1907</b>		9. AGE (In years last birthday) <b>52 yrs.</b>	IF UNDER 1 YEAR Months <b>9</b> Days <b>25</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Principal</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Public School Education</b>		11. BIRTHPLACE (State or foreign country) <b>Mc Dowell, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Rev. L. D. Yost</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Neff</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Marguerite M. Yost (Wife)</b> <b>Hagerstown, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Coronary Atherosclerosis, Severe</b> (c) <b>Recent</b> DUE TO (c) <b>Recent</b>							INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b></b> a. m. <b></b> p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>[Signature]</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>F. W. D. T. T. T.</b>						DATE SIGNED <b>9/30/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 3, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Elmwood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Shepherdstown, West Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. K. Brown</b>				ADDRESS <b>Martinsburg, W. Va.</b>		24a. REC'D BY REGISTRAR <b>OCT 4 '60</b>	
				24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10802

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MT. CARMEL RURAL</b>				c. LENGTH OF STAY IN 1b <b>20 YEARS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>KEEDYSVILLE MD. R.I.</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>FRANK S. ZIMMERMAN</b>				4. DATE OF DEATH <b>SEPTEMBER - 8 - 1960</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JANUARY 15 - 1901</b>	
9. AGE (In years lost birthday) <b>59 yrs.</b>		IF UNDER 1 YEAR <b>7</b> Months <b>23</b> Days		IF UNDER 24 HRS. <b>7</b> Hours <b>23</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>TENANT</b>			
11. BIRTHPLACE (State or foreign country) <b>DARGAN WASH. CO. MD. U.S.A.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>HENRY F. ZIMMERMAN</b>				14. MOTHER'S MAIDEN NAME <b>LUCY BADGER</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NO</b>			
17. INFORMANT <b>MRS. MARTHA ZIMMERMAN KEEDYSVILLE MD. R.I.</b>				Address <b>KEEDYSVILLE MD. R.I.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>420.1</b> DUE TO (c) <b>420.1</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NO</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 5, 1960</b> to <b>Sept 8, 1960</b> that (I) (we) lost saw the deceased alive on <b>Sept 8, 1960</b> , and that death occurred at <b>11 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>G. W. LeVan</b>				22b. DATE SIGNED <b>9/10/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>G. W. LeVan</b>				22d. ADDRESS <b>Boonsboro Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>SEPT. 11, 1960</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>BOONSBORO CEMETERY</b>				23d. LOCATION (City, town, or county) (State) <b>BOONSBORO WASH. CO. MD.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Dore</b>				25a. REC'D BY REGISTRAR <b>SEP 14 '60</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Finner</b>							

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WESTLAND STATE UNIVERSITY